

# Work Comp Intake

Please print out this form, complete it, and mail it to our office or you can complete and e-mail it to [intakes@durkinandhutson.com](mailto:intakes@durkinandhutson.com) or fax 817 545 5071

## IDENTITY

NAME: \_\_\_\_\_

DOI: \_\_\_\_\_

## ISSUE(S)

WHAT ARE YOU WANTING THE ATTORNEY TO DO FOR YOU? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

IF THE CLAIM IS BEING DENIED, WHY? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

ARE YOU CURRENTLY RECEIVING WEEKLY CHECKS **FROM THE CARRIER**? \_\_\_\_\_

IF SO, HOW MUCH IS IT? \_\_\_\_\_

HAVE YOU **EVER** RECEIVED ANY CHECKS? \_\_\_\_\_

DO YOU NEED A DOCTOR WHO SPECIALIZES IN WORKERS' COMP? \_\_\_\_\_

HOW DID YOU HEAR ABOUT US: \_\_\_\_\_

DO WE HAVE YOUR PERMISSION TO SHARE WHAT WE DISCUSS WITH YOUR DOCTOR?

\_\_\_\_\_

## COVERAGE

EMPLOYER/COMPANY NAME: \_\_\_\_\_

EMPLOYER ADDRESS: \_\_\_\_\_

EMPLOYER'S WORKERS COMP INSURANCE CARRIER NAME: \_\_\_\_\_

## INJURY

BRIEFLY EXPLAIN, HOW DID YOU GET HURT?: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

BODY PART INJURED: \_\_\_\_\_

ANY WITNESSES TO THE INJURY OR KNOW ABOUT IT? \_\_\_\_\_

IF SO, THEIR NAME(S): \_\_\_\_\_

WAS INJURY REPORTED/TO WHOM/WHEN? \_\_\_\_\_

JOB TITLE: \_\_\_\_\_

HOW LONG HAVE YOU WORKED FOR EMPLOYER?: \_\_\_\_\_

HOW MUCH MONEY WERE YOU MAKING AT THE TIME OF THE INJURY? \_\_\_\_\_

HAVE YOU HAD ANY OTHER INJURIES BEFORE (AT WORK AND NOT AT WORK INCLUDING  
MOTOR VEHICLE ACCIDENTS)? PLEASE LIST EACH OF THEM WITH THE DATE OF THE  
INJURY: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**DOCTORS - Please list all the doctor's information from all of  
those that have treated you since the injury occurred. Give  
details as to when you were taken off work and the dates.**

WHEN DID YOU FIRST SEE A DOCTOR & HOW LONG DID THEY TREAT YOU (DATE): \_\_\_\_\_

\_\_\_\_\_

WHAT DOCTOR OR CLINIC: \_\_\_\_\_

DATE: \_\_\_\_\_

TAKEN OFF WORK? \_\_\_\_\_

DID YOU GET WEEKLY CHECKS FROM THE WORK COMP INS CO? \_\_\_\_\_

WHEN DID YOU SEE THE NEXT DOCTOR & HOW LONG DID THEY TREAT YOU (DATE): \_\_\_\_\_

WHAT DOCTOR OR CLINIC: \_\_\_\_\_

DATE: \_\_\_\_\_

TAKEN OFF WORK? \_\_\_\_\_

DID YOU GET WEEKLY CHECKS FROM THE WORK COMP INS CO? \_\_\_\_\_

**KEEP LISTING ALL DOCTORS WITH ALL THE ADDITIONAL INFORMATION UNTIL YOU HAVE THEM ALL LISTED!!!**

CURRENT DIAGNOSIS (WHAT IS WRONG WITH YOU): \_\_\_\_\_

WHAT DOCTOR IS NOW KEEPING YOU OFF WORK? \_\_\_\_\_

LAST DATE YOU SAW A DOCTOR? \_\_\_\_\_

HAS ANY DOCTOR GIVEN YOU MMI/IR? (YES/NO) \_\_\_\_\_

**MMI/IR- Please state the MMI dates on all the Impairment Ratings. If you don't know you need to find them or call The Division of Workers' Compensation at 817.446.4488, or you can call the insurance company**

DOC NAME:

TYPE OF DOC (TREATING, RME, IME, OR DESIGNATED DOCTOR): \_\_\_\_\_

DATE OF THE EXAMINATION: \_\_\_\_\_

MMI: \_\_\_\_\_

IR: \_\_\_\_\_

DISPUTED BY WHO? \_\_\_\_\_

**IF THERE HAS BEEN MORE THAN ONE DOCTOR THAT HAS GIVEN YOU AN IMPAIRMENT RATING PLEASE LIST THEM ALL.**

**HAVE YOU BEEN TO ANY HEARINGS AT THE TEXAS WORKERS' COMP COMMISSION?**

HAVE YOU HAD ANY BRC'S OR DO YOU HAVE ONE COMING UP? \_\_\_\_\_

DATE? \_\_\_\_\_

ISSUE? \_\_\_\_\_

\_\_\_\_\_

OUTCOME? \_\_\_\_\_

HAVE YOU HAD ANY CCH's OR DO YOU HAVE ONE COMING UP? \_\_\_\_\_

DATE? \_\_\_\_\_

ISSUES? \_\_\_\_\_

\_\_\_\_\_

OUTCOME? \_\_\_\_\_

**HAVE YOU HAD AN ATTORNEY FOR THIS INJURY?**

WHO? \_\_\_\_\_

WHEN? \_\_\_\_\_

WHY DON'T YOU HAVE THEM NOW? \_\_\_\_\_

**INTAKE NOTES** - Please list any additional information that you consider important that was not previously covered above.