DURKIN LAW OFFICES, P.C.
RETURN TO:
Email intakes@durkinlegal.com
Fax 817 545 5071

Work Comp Intake

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.

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