LAW OFFICES OF
CHARLES D. NAYLOR

839 S. Beacon Street
Suite 311
San Pedro, CA 90731

Ph. (310) 514-1200
Fax (310) 514-1200
www.NaylorLaw.com

CLIENT INTERVIEW FORM

DEFENSE BASE ACT

Please fill out the following form to the best of your ability.

YOUR INFORMATION

First Name:_____ MI:_____ Last Name:_____

Address: _____

City: _____ State: _____ Zip:_____

Date of Birth:_____ SSN: _____

Marital Status: ❑ Married ❑ Single

Email Address:_____ Phone (home):_____

Phone (work): _____ Phone (cell): _____

Alternative Contact Info

Name:_____ Relationship:_____

Phone Number:_____

REFERRAL SOURCE INFORMATION

How did you find us?

❑ Website
❑ Internet Search
❑ Yellow Pages
❑ Longshore Injury Hotline
❑ Friend or Relative (see below)
❑ Another Lawyer (see below)
❑ Doctor or Medical Provider (see below)
❑ Other:

Please provide the following information about who referred you to us so we may thank them for their kind recommendation.

First Name:_____ Last Name:_____

Email Address:_____ Phone Number:_____

INJURY REPORTING

Date* of Injury: _____ Time of Injury: _____
**or last day worked if continuous trauma injury*

Time Shift Started: _____ Time Shift Ended: : _____

Supervisor's name at time of injury: _____

Was the injury / accident reported? ❑ Yes (see below) ❑ No

How did you report the injury / accident? ❑ Written ❑ Oral

When was the injury / accident reported?: _____

Who did you report the injury to?: _____

Do you have a copy of the injury / accident report? ❑ Yes ❑ No

Was a doctor's slip obtained? ❑ Yes (see below) ❑ No

Do you have a copy of the doctor's slip? ❑ Yes ❑ No

When did you stop work?: _____

When did your base pay stop?: _____

When did your overtime pay stop?: _____

YOUR EMPLOYEMENT

Employer on date of injury: _____

Date Joined: _____

Job Title: _____

Anticipated Duration of Job: _____ Date Discharged: _____

Are you still working? ❑ Yes ❑ No

Pay Rate

Base Pay Per Month: _____

Base & Overtime Per Month: _____

Vacation / Supplemental Per Month: _____

Money Purchase Plan: _____

YOUR EMPLOYER'S INSURANCE

Insurance Carrier: _____

Insurance Claim #: _____ OWCP Claim #: _____

Insurance Adjuster Info

Name: _____

Phone Number: _____

ABOUT THE INJURY / ACCIDENT

Facts about your injury / accident:

ABOUT THE INJURY / ACCIDENT *(continued)*

Nature of Injury (list all injuries, body parts affected and surgeries performed and/or recommended)

Medical Care (list each health care provider in the order seen and describe the general nature of treatment. Identify those providers with whom you are still seeking treatment).

PERIOD(S) OF DISABILITY & RETURN TO WORK

Temporary Total Dates: _____

Temporary Partial* Dates: _____
**Working with doctor's restrictions & with actual loss of earnings as a result.*

Permanent & Stationary Date: _____

Permanent Work Restrictions, if any: _____

_____

Return to Work Date(s): _____

WITNESS INFORMATION

If needed, additional Witness sheets can be downloaded: www.NaylorLaw.com/Resource/Forms

Witness #1

First Name: _____ Last Name: _____

Address: _____

Phone (home): _____ Phone (cell): _____

Email Address: _____

Can Testify To/About: _____

Witness #2

First Name: _____ Last Name: _____

Address: _____

Phone (home): _____ Phone (cell): _____

Email Address: _____

Can Testify To/About: _____

Witness #3

First Name: _____ Last Name: _____

Address: _____

WITNESS INFORMATION *(continued)*

Phone (home): _____ Phone (cell): _____

Email Address: _____

Can Testify To/About: _____

PRE-INJURY / ACCIENT INFORMATION

Factors affecting pre-injury / accident earning capacity

Any change of employment/job in the year (past 52 weeks) before or any time after the injury / accident?

❑ Yes (see below) ❑ No

Please provide information about your change of employment / job

Any unusual time off work in the year (past 52 weeks) before or any time after the injury / accident?

❑ Yes (see below) ❑ No

Please provide information about your time of work

Please provide information about any other factors affecting your pre-injury / accident earning capacity.

PRE-INJURY / ACCIENT INFORMATION (continued)

PRIOR INJURIES
(list nature of injury, health care providers, surgeries, lost time from work, amount of settlement/judgment and attorney)

Work Related

Non-Work Related

POST-INJURY / ACCIENT INFORMATION

Workers Compensation

For what period?: _____

Compensation Rate: _____

Temporary Total / Temporary Partial Disability

For what period?: _____

Compensation Rate: _____

Social Security Disability

For what period?: _____

Compensation Rate: _____

State Disability

For what period?: _____

Compensation Rate: _____

Private Disability

Provider: _____

For what period?: _____

Compensation Rate: _____