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CLIENT INTERVIEW FORM

LONGSHORE WORKERS

Interview Date:_____ Interviewed By:_____

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:_____

Union Information

Union Affiliation: _____ Registration #: _____

Book Status:_____ Dates: _____

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: _____

Steady? ❑ Yes (see below) ❑ No

How long?: _____

Pay Rate

Base Pay Per Month: _____

Base & Overtime Per Month: _____

Vacation / Supplemental Per Month: _____

Money Purchase Plan: _____

YOUR EMPLOYER'S INSURANCE

Insurance Provider (Primary): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Insurance Claim #: _____ OWCP Claim #: _____

Adjuster Name: _____

Phone: _____

Insurance Provider (Secondary): _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Insurance Claim #: _____ OWCP Claim #: _____

Adjuster Name: _____

Phone: _____

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

(#1) Office / Practice:_____ Dr Name:_____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

Date First Seen: _____ Date Last Seen: _____

Treatment Provided: _____

_____

_____

Are you still seeking treatment with this doctor? ❑ Yes ❑ No

(#2) Office / Practice:_____ Dr Name:_____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

Date First Seen: _____ Date Last Seen: _____

Treatment Provided: _____

_____

_____

Are you still seeking treatment with this doctor? ❑ Yes ❑ No

(#3) Office / Practice:_____ Dr Name:_____

Address: _____

City: _____ State: _____ Zip:_____

Phone: _____ Fax: _____

Date First Seen: _____ Date Last Seen: _____

Treatment Provided: _____

_____

_____

Are you still seeking treatment with this doctor? ❑ Yes ❑ No

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 INFORMATION *(continued)*

Witness #3

First Name: _____ Last Name: _____

Address: _____

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

Email Address: _____

Can Testify To/About: _____

PRE-INJURY / ACCIDENT INFORMATION

Have you had any workers' compensation cases / claims in the past? ❑ Yes (see pg 8) ❑ No

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

PRE-INJURY / ACCIDENT INFORMATION *(continued)*

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

PRIOR INJURIES
If needed, additional Prior Injury sheets can be downloaded: www.NaylorLaw.com/Resource/Forms

Work Related

(1) Date of Injury (DOI): _____ Employer on DOI: _____

Nature of Injury: _____

_____

DR Name: _____ DR Name: _____

Did your injury require surgery? ❑ Yes ❑ No If yes, date of surgery: _____

Did you lose time at work due to the injury? ❑ Yes ❑ No Time off work: _____

Did you file a claim under the LHWCA? ❑ Yes (see below) ❑ No

Attorney Name: _____

Case Status: ❑ Pending ❑ Settled Settlement Amount:_____

(2) Date of Injury (DOI): _____ Employer on DOI: _____

Nature of Injury: _____

_____

DR Name: _____ DR Name: _____

Did your injury require surgery? ❑ Yes ❑ No If yes, date of surgery: _____

Did you lose time at work due to the injury? ❑ Yes ❑ No Time off work: _____

Did you file a claim under the LHWCA? ❑ Yes (see below) ❑ No

Attorney Name: _____

Case Status: ❑ Pending ❑ Settled Settlement Amount:_____

Non-Work Related

(1) Date of Injury: _____

Nature of Injury: _____

_____

DR Name: _____ DR Name: _____

Did your injury require surgery? ❑ Yes ❑ No If yes, date of surgery: _____

Did you lose time at work due to the injury? ❑ Yes ❑ No Time off work: _____

Did you file a claim or lawsuit? ❑ Yes (see below) ❑ No

Attorney Name: _____

Case Status: ❑ Pending ❑ Settled Settlement Amount: _____

(2) Date of Injury: _____

Nature of Injury: _____

_____

DR Name: _____ DR Name: _____

Did your injury require surgery? ❑ Yes ❑ No If yes, date of surgery: _____

Did you lose time at work due to the injury? ❑ Yes ❑ No Time off work: _____

Did you file a claim or lawsuit? ❑ Yes (see below) ❑ No

Attorney Name: _____

Case Status: ❑ Pending ❑ Settled Settlement Amount: _____

POST-INJURY / ACCIDENT 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: _____