LAW OFFICE OF
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WORKERS' COMPENSATION PRE-CONSULTATION FORM

Please complete as much information as possible. If you do not know an answer, you may leave it blank.

1. CLIENT INFORMATION

Full Legal Name:	Date of Birth:
Age:	Phone:
Mailing Address:	
City:	State / ZIP:
Email:	Preferred Contact: ☐ Phone ☐ Text ☐ Email
Preferred Language:	Interpreter Needed? ☐ Yes ☐ No
Marital Status:	Spouse's Name:

Dependents (names and ages):

2. CLAIM INFORMATION

L&I Claim Number:	Date of Injury / Occupational Disease:
Employer of Injury:	

Type of Claim: ☐ Washington State L&I (State Fund) ☐ Self-Insured Employer ☐ Unsure

Current Claim Status: ☐ Open ☐ Closed ☐ Rejected/Denied ☐ Reopening Pending ☐ Unsure

Claims Manager / Adjuster:	Phone / Email:

Accepted conditions / body parts: _____

Are there conditions you believe should be covered but are not accepted? ☐ Yes ☐ No ☐ Unsure

If yes, please explain: _____

3. RECENT ORDERS & DEADLINES

Have you received any L&I or self-insured employer Order, Notice, or decision? ☐ Yes ☐ No ☐ Unsure

Date on Order:	Date Received:

Decision: ☐ Claim rejected ☐ Claim closed ☐ Reopening denied ☐ Condition denied ☐ Time-loss stopped/denied

☐ PPD award ☐ Vocational decision ☐ Overpayment ☐ Other: _____

Have you protested or appealed? ☐ Yes ☐ No If yes, when? _____

IMPORTANT: Please provide our office with a copy of any recent Order, Notice, or vocational decision as soon as possible.

4. WORK INJURY / OCCUPATIONAL DISEASE

Please briefly describe how the injury occurred or how the occupational condition developed:

_____

_____

Where did the injury occur:	Reported to employer? ☐ Yes ☐ No
Witnesses? ☐ Yes ☐ No	Incident report completed? ☐ Yes ☐ No ☐ Unsure

Witness names/contact information: _____

Injuries or medical conditions resulting from the claim: _____

5. POSSIBLE THIRD-PARTY CLAIM

Did someone other than your employer or a coworker cause or contribute to the injury? ☐ Yes ☐ No ☐ Unsure

Possible source: ☐ Motor vehicle accident ☐ Unsafe property/premises ☐ Defective equipment/product

☐ General contractor/subcontractor ☐ Another company/employee ☐ Other: _____

If yes, please explain: _____

6. MEDICAL TREATMENT

Current Attending Provider:	Clinic / Phone:

Other doctors / specialists: _____

Treatment received: ☐ ER/Urgent Care ☐ X-rays ☐ MRI/CT ☐ PT ☐ Chiropractic ☐ Injections ☐ Surgery ☐ Mental Health

Other treatment: _____

Are you contending any mental health conditions or injuries associated with this claim? ☐ Yes ☐ No

Surgery due to this claim? ☐ Yes ☐ No If yes, procedure/date: _____

Additional treatment/surgery recommended? ☐ Yes ☐ No If yes: _____

Treatment denied or delayed? ☐ Yes ☐ No If yes, what treatment? _____

Current work restrictions: _____

7. INDEPENDENT MEDICAL EXAMINATIONS (IME)

Have you attended an IME for this claim? ☐ Yes ☐ No ☐ Unsure

Date:	Doctor(s):

Do you have the IME report? ☐ Yes ☐ No Is another IME scheduled? ☐ Yes ☐ No ☐ Unsure Date: _____

8. EMPLOYMENT & WAGES

Employer at Time of Injury:	Job Title:
Job Duties:	
Hourly Wage / Salary:	Average Hours Per Week:

Regular overtime? ☐ Yes ☐ No Average overtime: _____ Bonuses/commissions/tips? ☐ Yes ☐ No

If yes, describe: _____

Employer contributed to medical/dental/vision insurance for you or dependents? ☐ Yes ☐ No

If yes, amount or details: _____

Room, board, housing, meals, or other employer-provided benefits? ☐ Yes ☐ No

If yes, describe: _____

Did you have another job at the time of injury? ☐ Yes ☐ No Do you have CAC Access to your Claim Online? ☐ Yes ☐ No

Other Employer:	Wage / Hours:

9. CURRENT WORK & BENEFIT STATUS

Last Day Worked:	Currently working? ☐ Yes ☐ No

If working: ☐ Regular/full duty ☐ Light/modified duty ☐ Reduced hours ☐ Different position

Light-duty/modified-duty job offered? ☐ Yes ☐ No Approved by attending provider? ☐ Yes ☐ No ☐ Unsure

Are you earning less now than at the time of injury? ☐ Yes ☐ No

Currently receiving: ☐ Time-Loss ☐ LEP ☐ Kept-on-Salary ☐ Unemployment ☐ No wage-replacement ☐ Other

If time-loss stopped, date of last payment: _____

10. VOCATIONAL REHABILITATION

Has a Vocational Rehabilitation Counselor (VRC) been assigned to your claim(s)? ☐ Yes ☐ No ☐ Unsure

Vocational Rehabilitation Counselor Name: _____

Current status: ☐ Ability-to-work assessment ☐ Vocational services ☐ Retraining plan ☐ Job analyses
☐ Vocational determination received ☐ Unsure

Current vocational concerns: _____

11. PRIOR INJURIES & CLAIMS

Prior injury/treatment involving the same body part(s)? ☐ Yes ☐ No

If yes, explain: _____

Previous workers' compensation claims? ☐ Yes ☐ No

If yes, approximate dates/injuries: _____ Other Claim #'s: _____

Prior motor vehicle accidents, personal injury claims, or other significant injuries? ☐ Yes ☐ No

If yes, explain: _____

12. PRIOR ATTORNEY REPRESENTATION

Have you spoken with or hired another attorney regarding this claim? ☐ Yes ☐ No

Attorney / Law Firm: _____ Are they still representing you? ☐ Yes ☐ No

If no, why did the representation end? _____

13. WHAT DO YOU NEED HELP WITH?

Please check all that apply:

☐ Claim rejected	☐ Claim closed
☐ Reopening denied	☐ Condition not accepted
☐ Treatment denied/delayed	☐ Surgery denied/delayed
☐ Time-loss problem	☐ Wage calculation problem
☐ Loss of Earning Power (LEP)	☐ Light-duty dispute
☐ IME concerns	☐ Vocational rehabilitation
☐ Permanent Partial Disability (PPD)	☐ Pension / Permanent Total Disability
☐ Overpayment	☐ Employer retaliation/discrimination concerns
☐ Third-party injury claim	☐ Other: (please explain)

14. ADDITIONAL INFORMATION

What is the most important thing you would like the attorney to know about your claim?

_____

_____

What would you like us to help you accomplish?

_____

_____

15. REFERRAL INFORMATION

How did you hear about our office? ☐ Former Client ☐ Friend/Family ☐ Attorney ☐ Medical Provider

☐ Google/Search ☐ Website ☐ Social Media ☐ Other: _____

Name of person who referred you, if applicable: _____

OFFICE USE ONLY

Date Intake Received:	Appointment Date:
Intake Completed By:	Conflict Check Completed: ☐ Yes

Recent Orders Reviewed for Deadlines: ☐ Yes Potential Third-Party Claim: ☐ Yes ☐ No

Attorney Review / Notes: _____

_____