Eklund Law Office LLC

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CLIENT INTAKE FORM

Name	AWCB Case No.	When were you injured? _____
Mailing address _____ _____	Phone: _____ Email: _____	
Date of Birth: _____	Employer (when you were injured): _____	
Workers' compensation insurance co. _____	Adjuster _____	Place of injury _____, Alaska

How long did you work for the employer before you were injured? _____

Job title: _____
Hourly wage/annual salary: _____
Are you married? _____ Do you have minor children? How many? _____

Have you received any workers' compensation benefits? If so, what type?
_____

Did you receive a controversion notice? _____ Did you file a Report of Injury? _____	Who is your treating physician? Does your physician agree that your disability and need for medical treatment is work-related?_____ _____ _____
Describe how your injury happened. _____ _____ _____ _____ _____ _____	Have you had past medical problems related to the same part of your body you injured in this work incident? If so, please describe: _____ _____ _____ _____

Do you have previous workers' compensation cases? If so, please list dates and case numbers, if available.
_____

Are you currently working? _____ If not, how long have you been off work? _____

Are you receiving any other benefits (unemployment benefits, Social Security disability benefits, retirement benefits)? _____

What is your monthly benefit amount? _____ When did you begin receiving this benefit? _____

Who referred you to Eklund Law Office? _____