

McMONAGLE STEINBERG & HESTER

1851 Heritage Lane, Suite 205

Sacramento CA 95815-4949

Ph: 916-568-1160 Fax: 916-568-1166

**INTAKE SHEET
WORKERS' COMPENSATION (WC)**

DATE: REFERRED BY: TO: PREP BY:

NAME:

ADDRESS:

PHONE: Cell Home DOB:

EMPLOYER AT TIME OF INJURY:

DATE HIRED:

OCCUPATION / JOB TITLE:

DATE(S) OF INJURY:

BODY PARTS INJURED:

HOW DID INJURY OCCUR?

WC INSURANCE CARRIER:

DATE CLAIM FORM (WC-1) COMPLETED:

CLAIM ACCEPTED?

TIME LOST FROM WORK DUE TO INJURY:

CURRENTLY RECEIVING BENEFITS?

LIMITATIONS DUE TO INJURY:

TREATING PHYSICIAN(S):

PRIOR WC CLAIMS?

CURRENT WC ATTORNEY?

APPOINTMENTS SCHEDULED?

ADDITIONAL INFORMATION:

REVIEWED BY: _____ COMMENTS: _____

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**INTAKE SHEET
SOCIAL SECURITY (SS)**

DATE: REFERRED BY: TO: PREP BY:

NAME:

ADDRESS:

PHONE: Cell Home DOB:

DATE OF APPLICATION:

For Social Security Disability Insurance (SSDI):

For Supplemental Security Income (SSI):

DATE OF DENIAL LETTER:

DATE OF APPEAL:

DISABILITY

INJURIES / ILLNESSES:

LIMITATIONS:

TREATING DOCTOR(S):

EMPLOYMENT

LAST EMPLOYER:

JOB TITLE:

LENGTH OF EMPLOYMENT:

DATE LAST WORKED:

WC CLAIM FILED? IF YES, ATTORNEY OF RECORD:

ADDITIONAL INFORMATION:

REVIEWED BY: _____ COMMENTS: _____
