

Strom & Associates, LTD.  
180 N. LaSalle, Suite 2510  
Chicago, IL. 60601  
(T) 312-609-0400  
(F) 312-609-0578

DATE \_\_\_\_\_

**WC INFORMATION SHEET**

Referring Attorney: \_\_\_\_\_

Client's Name \_\_\_\_\_

Sex: Male \_\_\_ Female \_\_\_ Date of Birth \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Telephone \_\_\_\_\_ Social Security Number \_\_\_\_\_

Spouse's Name \_\_\_\_\_

Relative \_\_\_\_\_

Children Under 18 at Date of Accident:

Name	Age	Name	Age
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Employer: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ Zip \_\_\_\_\_

Length of Employment \_\_\_\_\_ Phone \_\_\_\_\_

Name of Foreman \_\_\_\_\_

Type of Work: \_\_\_\_\_

Weekly Wages: \_\_\_\_\_

**Accident**

Date: \_\_\_\_\_ Time: \_\_\_\_\_

Place: \_\_\_\_\_ City: \_\_\_\_\_



**Clinic or  
Hospital** \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

Name of Treating Physician \_\_\_\_\_

**Clinic or  
Hospital** \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

Name of Treating Physician \_\_\_\_\_

**Clinic or  
Hospital** \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

Name of Treating Physician \_\_\_\_\_

**Clinic or  
Hospital** \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_

Name of Treating Physician \_\_\_\_\_

Type of  
Treatment \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Visits: \_\_\_\_\_ Date of last visit: \_\_\_\_\_

Time lost from Work \_\_\_\_\_

Was T.T. Paid \_\_\_\_\_ Amount: \_\_\_\_\_

Medical Attention Other Than That Provided by Company

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Subjective  
Complaints \_\_\_\_\_

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