PROMET PHYSICAL THERAPY, P.C.
NO FAULT AND WORKER'S COMP. QUESTIONNAIRE

Date: _____

Patient Name: _____

Social Security Number: _____

What type of report are you filing (circle one)? No Fault or Worker's Comp

Carrier Case Number/ Case Number _____

Policy Holder _____

Policy Number _____

Date of Accident/Injury _____

Address where injury occurred _____

_____

Date last report filed _____

How did the accident/injury occur? _____

Is there a history of pre-existing injury / disease? YES NO

Is the patient working? YES NO

Name & Address of Employer _____

_____

Phone Number of Employer _____

Is the patient disabled from regular work duties? YES NO

Is the disability total or partial? _____

Is treatment related to disability? YES NO

When did the symptoms first appear? _____

Diagnosis and Concurrent Conditions _____

Have you been admitted to a hospital within the last 60 days? YES NO

If Yes, name of hospital: _____ Date of Hospital Stay: _____

Is there an attorney involved (if "Yes," complete information below)? YES NO

Attorney/Case Worker _____

Address _____

Phone Number _____

By signing below, I acknowledge that all the information provided above is true and accurate to the best of my knowledge.

Patient / Parent of Legal Guardian Signature Date