Clear Form

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

Date: _____

Patient Name: _____

What type of report are you filing (circle one)? ◯NO FAULT ◯WORKER'S COMP

Case Number _____

Date of Accident/Injury

How did the accident/injury occur? _____

_____

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

Is the patient working? ◯YES ◯NO

If Worker's Compensation case, Employer Name/Address:

_____

_____

Is the patient disabled from regular work duties? ◯YES ◯NO

Is the disability total or partial? ◯TOTAL ◯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

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

Attorney Name _____

Address _____

_____

Phone Number _____

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

_____

Printed Name of Patient/Parent or Legal Guardian

_____

Patient/ Parent or Legal Guardian Signature Date