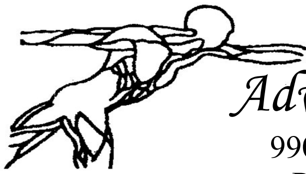

Advantage Physical Therapy
990 Cedar Bridge Ave, Brick, NJ 08723
Ph 732 262-0111 Fax 732 262-0332

Worker's Compensation Questionnaire

Patient Name: ____________ SS#: ____________ DOB: ____________

What part(s) of your body did you injure at work? ____________

What **date** did your injury occur? (Be as specific as possible) ____________

How did your injury occur? ____________

____

Did anyone witness your injury? ☐ Yes ☐ No If **yes**, who? ____________

What **date** did you report the incident to your employer? ____________

What **date** were you first evaluated and/or treated for this medical condition? ____________

Have you stopped working as a result of this injury? ☐ Yes ☐ No

If **yes**, date you stopped working? ____________ Are you still off work due to this injury? ☐ Yes ☐ No

Have you ever had a similar medical problem or injury? ☐ Yes ☐ No If **yes**, when?

If **yes**, please describe the similar medical problem or injury: ____________

____

Have you received previous treatment for your injury?	☐ Yes	☐ No

If **yes**, please list ANY and ALL sources and dates of treatment below:

Who treated you?	**Date?**

Please provide us with the following information:
(You can obtain this information from your employer)

Workers' Compensation Insurer:	
Address:	
Telephone #:	
Contact Name:	
Claim #:	

Have you retained an attorney?	☐ Yes	☐ No

If **yes**, please provide us with the following information:

Attorney's Name:	
Address:	
Telephone #:	

Patient Signature: ____________ Date: ____________