

**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    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 and address 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.

\_\_\_\_\_  
Printed Name of Patient/Parent or Legal Guardian

\_\_\_\_\_  
Patient/ Parent or Legal Guardian Signature

\_\_\_\_\_  
Date