



WORKERS COMPENSATION QUESTIONNAIRE

Name: _____

Address: _____

SS #: _____

Employer: _____

Emp. Address: _____

Emp. Phone #: _____

Date of Injury: _____

Address where injury occurred:

How did injury occur?

Were you hospitalized? _____

If yes, where? _____

Were X-Rays taken? _____

Were you previously under the care of another doctor?

If yes, please write their name _____

Is treatment continuing? _____

On what date will you be able to resume regular work? _____

Are you working at the time of this treatment? _____

Are you receiving additional treatment for this condition (Chiro, Acupuncture, Etc.)

WCB #: _____

WC Claim #: _____

Ins. Carrier: _____

Ins. Address: _____

Ins. Phone #: _____

I accept financial responsibility and promise to pay for all charges billed by Excel Physical Therapy to this account.

Signature: _____

Date: _____