Priority Physical Therapy, Inc.
Health Is Our Priority; Make It Yours.

Worker's Compensation

Patient Name:_____

Employer:_____

Employer Address:_____

Phone # of Employer:_____

Employer Contact Name:_____

Date of Injury:_____ Time if Possible:_____

Was this an AUTO or NON AUTO related accident?

Did you leave work: Y or N

If so, how long were you off of work due to injury:_____

Are you on any kind of leave pay: Y or N If so, what kind:_____

Did you have Chiropractic treatment: Y or N If so, dates:_____

Did you require hospitalization: Y or N If so, dates:_____

Did you require an ambulance: Y or N

SSN:_____
Attorney Information:

For Office Use Only

Patient Status: _____disabled
_____very sick
_____requires assistance constantly
_____cares for self
_____normal activity with effort
_____normal; minor signs of disease
_____normal; no complaints

Claim #_____