SYNERGY REHAB AND CHIROPRACTIC, LLC 105 TERRY DR, STE 114

NEWTOWN PA 18940 215.860.9798

WORKMAN'S COMP

*PATIENT NAME:*_____*DATE OF BIRTH:*_____

1. What was the date of the injury?_____
2. What time did the injury occur?_____
3. What is the name of your employer?_____
4. What is the street address of your employer? _____
5. What is the City, State, and Zip of your employer? _____
6. What is the name of your attorney? _____
7. What is the street address of your employer? _____
8. What is the City, State, and Zip of your attorney? _____
9. Please describe your incident in a few sentences: _____

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10. Did you report the incident to your supervisor? _____
11. What is your Supervisor's name? _____
12. Did your employer send you to a doctor? If yes, please provide the doctor's name _____
13. Did you go to a doctor on your own? If yes, please provide the doctor's name _____
14. Are there any other problems that affect your employment? _____
15. Does your job cause you to favor one side of your body? _____
16. Before the injury, were you capable of performing equal work with others your age? _____
18. Have you injured this area before? -yes - no

SIGNATURE OF PATIENT OR GUARDIAN:_____

PRINTED NAME:_____

DATE:_____