SYNERGY PHYSICAL THERAPY 7625 Maple Lawn Blvd Suite 140, Fulton, MD 20759-2565
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INJURY INFORMATION : GENERAL

If Work-related injury, please provide the following:
Employer Name:_____
Employer Address: _____
_____
Employer Phone: _____

Patient Name _____

Date of Injury _____

1. How did the accident occur? ☐ Auto ☐ On-the-job ☐ Other

2. Have you filed claim for your accident? (auto or worker's compensation claim)? ☐ Yes ☐ No

(For auto) was the file claimed with ☐ Your auto insurance ☐ other insurance (3rd party)

If yes, please provide claim # _____ $ of PIP coverage on policy _____

And case adjuster name and contact # _____

3. Describe your injury and how it occurred _____

_____

4. Describe how you felt during and after the injury: _____

_____

5. Are your symptoms ☐ getting better ☐ getting worse ☐ no change

6. Did you return to work on the day of the injury? ☐ Yes ☐ No

Have you lost time from work since the injury? ☐ Yes ☐ No

7. What are your work responsibilities? _____

Which work activities are affected by the injury? _____

Have your work responsibilities changed as a result of this injury? ☐ Yes ☐ No

Explain: _____

What other daily activities are affected by this injury? _____

_____

8. Did you go to the emergency room? ☐ Yes ☐ No Were you hospitalized? ☐ Yes ☐ No

List the health care providers who have treated you for this injury, the type of treatment provided:

1) _____

2) _____

9. Did you have any physical complaints before the injury? ☐ Yes ☐ No

Explain: _____

Do you have any illness or previous injuries that may have been affected by this injury? ☐ Yes ☐ No

Explain: _____

10. Has PIP application been submitted? ☐ Yes ☐ No

Has attorney been consulted? ☐ Yes ☐ No Retained? ☐ Yes ☐ No

If yes, attorney name and contact # _____