Worker's Compensation Information

Smith Physical Therapy & Wellness, P.C.

Patient Name: _____ **Today's Date:** _____

Employer Information:

Name of Employer: _____

Address: _____ City: _____ State: _____ Zip: _____

Contact Person: _____ Phone #: _____

Employer Insurance Information:

Insurance Carrier: _____ Phone #: _____

Address: _____ City: _____ State: _____ Zip: _____

Claim #: _____

Adjuster Name: _____ Adjuster Phone #: _____

Job Description:

Job Title:_____

How long have you been at your current job? _____

Are you presently working? ☐ Yes ☐ No

→ **If yes,** ☐ Full Duty _____ hours daily

☐ Modified Duty _____ hours daily

What restrictions, if any, have been put in place? _____

_____

_____

_____

→ **If no,** how long have you been off from work? _____

What physical requirements of your job are you particularly concerned with? _____

_____

_____

_____

➡ **I verify that the above information is accurate to the best of my knowledge.**

Signature: _____ **Date:** _____