pain management
AT GARDEN STATE MEDICAL CENTER

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WORKER'S COMPENSATION

Patient Name:_____ **Date:** ___/____/_____

WC Insurance Name:_____ **Date of Accident:** ___/____/_____

Attorney name: _____ **Tel:** _____

Attorney Address: _____ **State:**_____ **Zip code:** _____

Body part(s) injured while at work:_____

Cause and circumstances of accident: _____

_____

Employer: _____ **Occupation:** _____

Employer Address: _____ **State:**_____ **Zip code:** _____

Employment status: □Full time □Part time □As needed

Did you report your accident that day? □Yes □No **To whom:** _____

Did you complete your work duties that day: □Yes □No

How many days of work did you miss immediately after the injury: _____

Are you working now: □Yes □No **If no, last day of work:** ___/____/_____

When did you first seek medical care? _____ **With whom/where:** _____

Have you had any Physical Therapy? □Yes □No **If yes, who?** _____

Have you had any Chiropractic treatment? □Yes □No **If yes, who?** _____

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Have you seen any other Pain management doctors? □Yes □No **If yes, who?** _____

What treatment have you had up to now? _____

Any chronic/pre-existing injuries contributing to current injury: _____

_____

Have you had any other occurrences? □Yes □No **If yes :** □Work □Slip and fall
□Motor Vehicle □Sports injury

What injuries did you sustain as a result of other occurrences: _____

What treatment did you have for previous occurrence: _____

_____

Did those injuries resolve: □**Yes** □**No**

If no, what injuries are you still undergoing treatment for: _____

Do you have another job? □Yes □No **If yes, Employer name:** _____

Employer Address: _____ **State:**_____ **Zip code:** _____

Patient signature: _____ **Date:** ___/____/_____