



No Fault and Workman's Comp. Questionnaire

Date: _____

Patient Name: _____

What type of report are you filing? No Fault or Workman's Comp

Carrier Case Number/ Claim Number _____

Policy Holder _____

Policy Number _____

Date of Accident/ Injury _____

Address where injury occurred _____

Date last report filed _____

How did the accident/ injury occur?

Is there a history of pre-existing injury / disease?

Is the patient working? Yes / No

Name and address of employer _____

Is the patient disabled from regular work duties? Yes / No

Is the disability total or partial?

Is treatment related to disability?

When did the symptoms first appear? _____

Diagnosis and Concurrent Conditions _____

Have you been admitted to a hospital within the last 60 days? Yes / No

If Yes name of Hospital: _____ Date of Hospital Stay: _____