"Reaching Peak Performance"

Valdosta Physical Therapy, Inc.

Workers' Compensation Consent Form

We welcome you to our office and appreciate the opportunity to provide you with physical therapy / rehabilitation services.

If you have any questions, please do not hesitate to ask. Please read the statement below and sign.

I consent to receiving physical therapy / rehabilitation services, which are deemed medically necessary by my referring and/or primary care physicians or physical therapists. I authorize the release of medical information to my referring physician and insurance company.

I have read the above information and I understand these policies.

Print Name:_____PatientSignature:_____Date:_____

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Worker's Compensation Questionnaire

Name:_____ Date:_____

Please answer the following questions regarding your injury and its affects on your ability to work.

1. What was the date of the injury we are treating you for?_____
2. How were you injured?_____
   _____
3. What were your job duties at the time of your injury?_____
   _____
4. Were you able to continue working at the time of your injury?_____
   _____
5. If you were unable to continue working, how long were out of work?_____
   _____
6. Are you working now?_____
7. If you are working now are you doing the same job duties you were before your injury?_____
   _____
8. If you are working now but not the same job how are your job duties different than they were before your injury?_____
   _____
9. If you are not working now, why are you out of work?_____
   _____
10. If you are not working now are you planning to return to the same job?_____
11. If you are not planning to return to the same job, what type of job are you planning to do or wish to do?_____
12. Is there any other information regarding your ability to work or goals for returning to work that

you feel would assist us in your physical therapy treatment?_____
_____