CLIENT PERIODIC REVIEW FORM

Your file came up for review & we ask that you answer the following questions.

1. Full Name:

_____

2. If your current mailing address is different than the address written above, please write your new address here.

_____

3. Please write your email address and phone number(s) where we can reach you.

_____

_____

4. Please tell us the name, address and telephone of the health care provider(s) you are treating with, what treatment you are receiving, and who is paying for it. If you are not treating, please say so.

_____

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5. Are you taking any medications? If so, provide the name of the medication(s), the dosage, and the frequency that you use it, and who pays for it.

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_____

6. Have you developed any new problems that you think are related to your work injuries? Please explain.

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7. Are you currently employed? If so, who is your employer?

_____

8. Are you receiving Social Security Disability Income (SSDI) or Social Security Supplemental Income (SSI)? If so, please state the date when you received your SSDI or SSI award. If you are not receiving SSDI or SSI, are you interested in pursuing that benefit?

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9. Are you currently Medicare eligible, even if you are not using Medicare at this time? If so, please state the date when you became Medicare eligible.

_____

10. Would you be interested in settling your claim and receiving a lump sum settlement?

_____

Thank you in advance for providing your feedback.

Send finished form to records@ghitterman.com or bring with you day of apt.