NEW CLIENT -- DISABILITY RETIREMENT

BACKGROUND

Name:_____

Address: _____

Cell Phone/Home No.: _____

Email Address: _____

Date of Birth: _____ SSN: _____

Primary Language: _____ Need Interpreter? _____

Emergency contact (Name, Relationship, Cell Phone) _____

_____

How were you referred to us?_____

Employer at the time of your injury:_____

Address and Phone: _____

What is your job title?_____

Date of hire: _____Last day of work:_____

If there is an insurance company that is handling your claim, please state the name, address, phone number, and claim number: _____

_____

If you have an adjustor that is assigned to your claim, please state the Name, address, phone and email address: _____

_____

Name, address & phone number of each health care provider that you have seen for your work injury:_____

_____

_____

_____

Name, Address, phone and email address for your family doctor: _____

INJURY(s)

If your injury happened on a specific day, what was the date of your injury and how did it happen (if you have more than one specific injury, please list the date and how you were hurt on that date)? _____

_____

_____

Who did you tell at work that you were hurt and when did you tell them: _____

_____

If your work injury happened over time, when did you first notice the onset of symptoms? _____

If your injury happened over time, please describe the job duties you believe contributed to your work injury:_____

_____

_____

Please identify *any and all* body parts you believe are related to your work injury:

_____

_____

Before your work injury, did you ever have problems/symptoms/treatment with *any or all* of the body parts involved in your work injury? [Please note that having a pre-existing condition does NOT disqualify you from receiving benefits] If yes, please describe the body part, the problems, symptoms and/or treatment for each body part: _____

_____

_____

Please indicate if you have *ever* had problems with the following conditions:

High blood pressure _____ Hypertension ____ Diabetes _____ Heart _____

Auto-Immune _____ Endocrine system _____ Respiratory _____

Gastrointestinal _____ Kidney _____ Urology _____ Cancer _____

Hearing ____ Vision _____ Neck _____ Back _____ Shoulders _____

Elbows _____ Wrists _____ Hips _____ Knees _____ Ankles _____ Psyche ____

If yes to any above, please describe the problem and when it first started: _____

_____

_____

Please describe *any and all* restrictions on your ability to work that existed *before* your work injury: _____

EARNINGS

If you have missed time from work, when was the last day you performed work for your employer: _____

What were your wages on the day of injury: $_____ per hour

Hours worked per week: _____ Overtime: _____

If you had a second job when you stopped working, please identify the name, address and phone number of that employer _____

_____

What wages did you earn in this second job? _____

If you have received money since you have been off work, how much are you receiving every two weeks and who is paying it? _____

_____

If you have returned to work, what is the date you did so? _____

Send completed form to newclientinfo@ghitterman.com or bring with you day of apt.