

LAW OFFICES OF ROBERT T. BLEDSOE  
SUBSEQUENT INJURIES BENEFITS TRUST FUND  
QUESTIONNAIRE

Name:		DOB:	SSN:
Address:		Primary Physician:	Mr. / Ms. / Mrs.
Phone:	E-mail	Interpreter:	

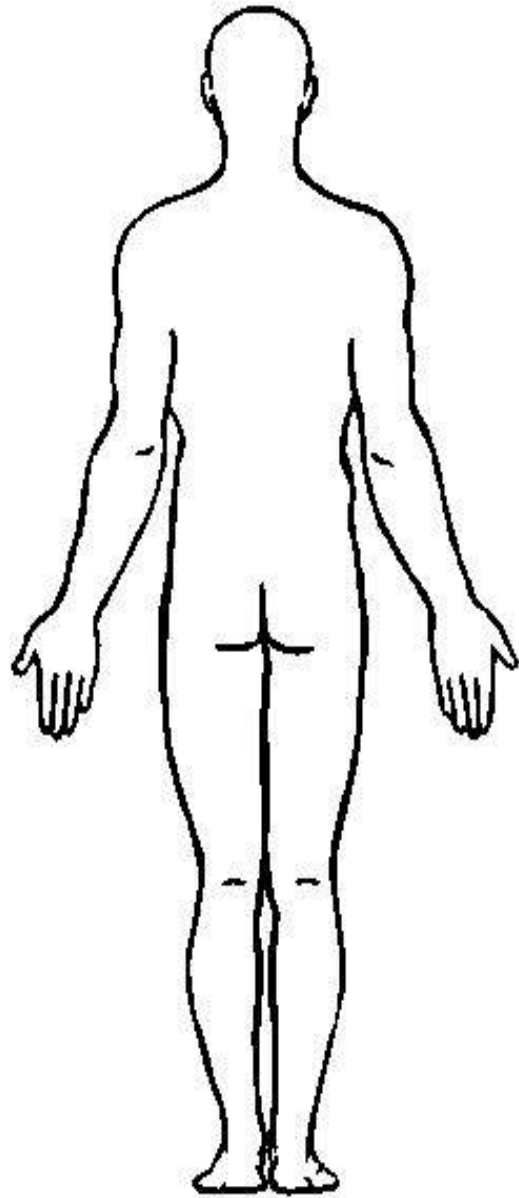
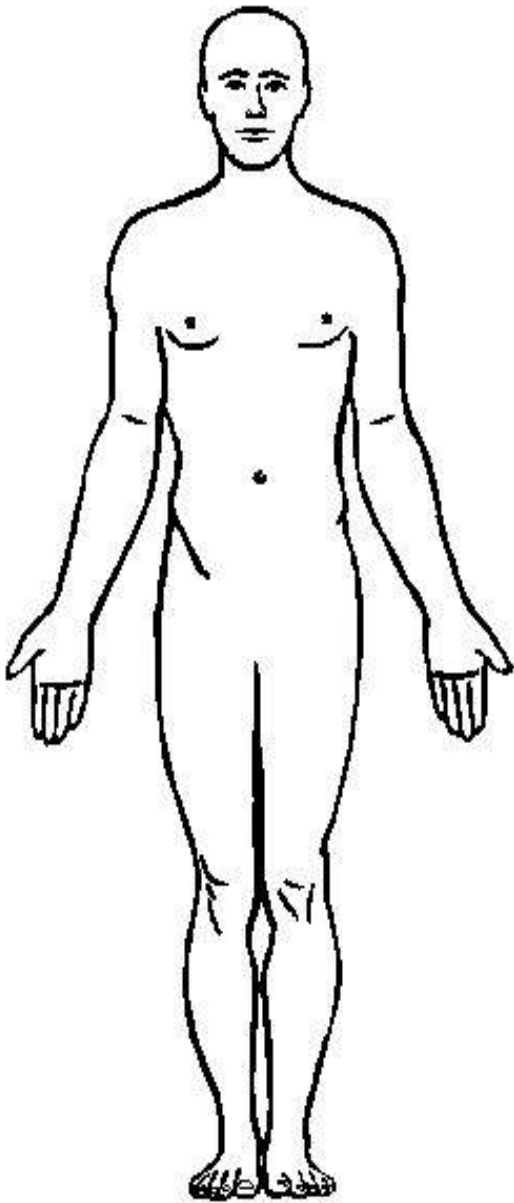
1. How was your case settled?      Stipulations     Compromise & Release     Findings & Award
2. What disability rating were you awarded? \_\_\_\_\_
3. Are you Still Working?    Yes     No
4. Have you Retired?      Yes     No
5. Do you think you are able to work at this time?    Yes     No
6. Are you receiving any of the following?    SS Disability     Disability Retirement     Any Other Type of benefit  \_\_\_\_\_

“x”	Pre-existing Conditions including sports injuries and injuries as a child:	Date Diagnosed:
	Heart – Heart Attack, etc.	
	Sleep	
	High Blood Pressure – Hypertension	
	Heart Defect	
	Arteries / Veins	
	Stomach	
	Blood Clots	
	Stroke	
	Cholesterol	
	Diabetes	
	Thyroid	
	Prostate	
	Kidney	
	Bladder	
	Hernia	
	Ears (Internal)	
	Nose	
	Eyes	
	Vision	
	Brain	
	Cancer	
	Arthritis	

“x”	Pre-existing Conditions including sports injuries and injuries as a child:	Date Diagnosed:
	Throat	
	Respiratory System – Lungs, etc.	
	Cancer	
	Skin	
	Hearing	
	Sinus	
	Back – Spine, Upper and Lower, etc.	
	Neck	
	Arms – Hands, Elbows	
	Torso – Ribs, Chest, etc.	
	Head	
	Hips	
	Legs	
	Knees	
	Shoulders	
	Psyche	
	Upper Extremity	
	Lower Extremity	
	Abdomen	
	Mouth – Teeth, Tongue, etc.	
	Sexual Dysfunction	
	Other:	



Please mark with an "x" where it hurts.



Please list your questions or concerns below:

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