

SLIP AND FALL QUESTIONNAIRE

FULL NAME: _____ SOCIAL SECURITY NO: _____

DATE OF BIRTH: _____ AGE: _____

ADDRESS: _____

CITY, STATE & ZIP CODE: _____

PHONE NUMBERS: (Home) _____ (Work) _____

(Cell) _____ (Alt #) _____

PHONE # (WHERE WE CAN LEAVE A MESSAGE IF YOU ARE NOT HOME): _____

(Please note that in the questions where there are multiple-choice answers, you should circle the correct answer)

MARITAL STATUS: Single Married Widowed Separated Divorced

IF MARRIED, FULL NAME OF SPOUSE _____

DO YOU HAVE AN ATTORNEY? ___ YES ___ NO. IF YES HIS/HER NAME, PHONE NUMBER AND ADDRESS

ARE YOU NOW RECEIVING ANY TYPE OF GOVERNMENTAL ASSISTANCE SUCH AS SOCIAL
SECURITY, MEDICAID, MEDICARE, ETC.? _____ IF YES, WHAT TYPE OF ASSISTANCE

IF NOT, DO YOU ANTICIPATE RECEIVING ANY OF GOVERNMENTAL ASSISTANCE OF ANY KIND IN THE
FUTURE? _____ IF SO, WHAT TYPE? _____

INSURANCE INFORMATION

WHERE DID THE ACCIDENT OCCURRED: _____

LOCATION OF WHERE ACCIDENT OCCURRED: _____

NAME OF INSURANCE COMPANY, IF KNOWN: _____

NAME OF HEALTH INSURANCE: _____

HOW DID THIS SLIP AND FALL OCCUR? PLEASE STATE EXACTLY WHAT HAPPENED TO CAUSE YOU TO
FALL: _____

DATE OF ACCIDENT: _____

NAME OF PERSON YOU NOTIFIED ABOUT INJURY HIS/HER POSITION?

DID YOU GO TO THE HOSPITAL? _____ YES _____ NO. IF YES, WHICH ONE DID YOU GO TO?

WERE X-RAYS TAKEN _____ YES _____ NO. IF YES, OF WHAT AREA _____

OTHER IMAGING STUDIES DONE? _____

HOW WERE YOU TRANSPORTED? AMBULANCE _____ CAR _____

WHEN DID YOU FIRST SEE A DOCTOR? _____

LIST ALL DOCTORS AND THEIR PHONE NUMBERS YOU HAVE SEEN IN RELATION TO THIS ACCIDENT
AND THEIR SPECIALITY: _____

WERE THERE ANY WITNESSES TO THIS ACCIDENT? ___ YES ___ NO ___ NOT SURE

LIST ALL ILLNESSES OR ACCIDENTS THAT YOU HAVE SUSTAINED OR BEEN IN EITHER BEFORE OR
AFTER THIS ACCIDENT: (NOTE: This includes automobile accidents, worker's compensation injuries, slip and fall
accidents and/or any other kind of injury or chronic illness)

DAMAGES

WERE YOU EMPLOYED AT THE TIME OF THE ACCIDENT?___ YES___ NO

IF SO WHERE:

NAME OF COMPANY. ADDRESS & PHONE NUMBER_____

EMPLOYER'S COUNTY & STATE: _____

DATE YOU BEGAN WORKING THERE: _____

NUMBER OF HOURS WORKED DURING AN AVERAGE WEEK: _____

YOUR JOB TITLE AND DESCRIPTION OF YOUR DUTIES AND RESPONSIBILITIES:

HAVE YOU LOST ANY TIME FROM WORK BECAUSE OF THIS ACCIDENT? __YES__ NO

IF YES, PLEASE ANSWER THE NEXT FOUR QUESTIONS:

1. DATE YOU FIRST MISSED TIME FROM WORK DUE TO THIS ACCIDENT:

2. ARE YOU STILL OUT OF WORK?___ YES___ NO

3. HOW MANY DAYS DID YOU MISS FROM WORK AS A RESULT OF THIS

ACCIDENT? _____

4. WERE YOU FIRED OR LAID OFF BECAUSE OF THE TIME THAT YOU HAVE MISSED/ARE
MISSING FROM WORK DUE TO YOUR INJURIES RECEIVED IN THIS ACCIDENT?___ YES___ NO

MEDICAL HISTORY

WHAT INJURIES DID YOU SUFFER FROM AS THE RESULT OF THIS ACCIDENT?

[illegible]

REMEMBER; PLEASE ANSWER ALL OF THE ABOVE QUESTIONS. IF A QUESTION IS NOT APPLICABLE, PLEASE MARK IT "N/A". THANK YOU.

PATIENT SIGNATURE----- DATE-----