ACCIDENTAL INJURY QUESTINNAIRE
(SLIP OR FALL)

Today's Date: _____

Please fill out he answers to the following questions to the best of your ability. If you have difficulty with any questions or are unsure how best to answer, please discuss those questions with the doctor before answering.

Last Name: _____ First Name: _____
Age: _____ DOB:_____Weight: _____ Height: _____
Are you: ( ) Married ( ) Single ( ) Divorced ( ) Separated ( ) Widowed ( ) Living with a significant other
Are you a parent? NO, YES, with 1 2 3 4 5 6 Children
Occupation _____ for how long _____years _____months
Date of accident: (___/___/_____) Which state this the accident take place in? _____

Where and how did the accident happen? _____
_____
_____
_____
Did you report the injury? **YES or NO**
To whom? _____ Their title or position _____
Have you had any other accidents or injuries since this accident? **No, if Yes, please explain** _____
_____

Please complete one or more of the following statements:

1) Since the accident, I have been **unable** to _____
_____
Example: Since the accident, I have been unable to go to school, make the beds, clean the house, drive the car or put on my own shoes.
Example: Since the accident, I have been unable to play basketball, help around the house or go running like I used to.

2) Since the accident, I have had **difficultly** _____
_____
Example: Since the accident, I have had difficulty playing basketball, helping around the house or with the kids.

3) Since the accident I **have** been able to continue with most of my daily activities.
_____
_____

I have not been able to work ( ) since the accident, or sine (___/___/____)

( ) I have not seen a doctor for this injury until now. This appointment is my first since the accident.
( ) I have seen a doctor _____ Date: _____
Address: _____
_____

Dr. Initial:_____