SLIP & FALL RELATED ACCIDENT INFORMATION

LAST:_____**FIRST:**_____ **DATE:**_____

Claim#:_____ **DATE OF ACCIDENT:**_____

Insurance Company:_____

Claim Adjuster:_____Phone:_____

Have you contacted an Attorney? ____Yes ____No

Attorney's Name:_____Phone:_____

Address:_____

Immediately after the accident, did you feel dazed? ____Yes ____No

Did you lose consciousness? ____Yes ____No

Was your head injured? ____Yes ____No

Immediately after the accident, did you experience? ____Headache ____Neck Pain ____Low Back Pain

Did you see another doctor before coming here? ____Yes ____No

Did you go to a hospital after the accident: ____Yes ____No If yes, which hospital?_____

How did you get to the hospital? ____Ambulance _____Drove Self _____Police _____Somebody else

Were any of the following tests performed at the hospital? ____Yes ____No

____XRAYS ____MRI ____CT SCAN ____LAB WORK

Have you lost time from work? ____Yes ____No

Can you perform physical work activities? ____Yes ____No

If no, because of: ____Pain ____Weakness ____Stress

Can you go to sleep without problems? ____Yes ____No

Do you awaken because of pain? ____Yes ____No

Did you have sleep problems before? ____Yes ____No

SIGNATURE:_____**DATE:**_____