

Dawn M. Hill D.C.
2700 North O'Connor #126
Irving, Texas 75062

Phone (972) 258-6647 www.hillchiropractic.com Fax (972)258-6220

PERSONAL INJURY QUESTIONNAIRE
(Slip and Fall)

Name: _____ Date of Birth: _____

Address: _____ City: _____

State: _____ Zip Code: _____ Home Phone No: () _____

Employer: _____ Work Phone No: () _____

Address: _____ Your Social Security No: _____

Do you have Insurance? Yes No

Your Insurance Company: _____ Policy No: _____

Have you retained an Attorney? Yes No If YES, Attorney's Name / Phone: _____

Were there any Witnesses? Yes No Names: _____

NATURE OF ACCIDENT

Nature of the Accident: Lifting Fall Other _____

Date of Accident: _____ Time of Day: _____ A.M. P.M.

Place of Accident: _____

DESCRIBE HOW ACCIDENT HAPPENED: _____

INJURY: Describe where you hurt after the Accident / Injury:

1. _____

2. _____

3. _____

SYMPTOMS YOU NOW HAVE: _____

Were you seen by another Doctor for this condition before today? Yes No Date: _____

If YES, please furnish us with their Name and Address: _____

Type of Doctor: _____ Diagnosis: _____

What TYPE OF TREATMENT did you receive? _____

Have you lost any time from work as a result of the Accident / Injury? Yes No

What was the last day you worked? _____

Patient's Signature

Date