



## Slip & Fall / Injury Questionnaire

Date of Accident: \_\_\_\_\_ Time of Accident: \_\_\_\_\_

Property Owner/Business Name: \_\_\_\_\_

Location of Incident (address): \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Was the incident reported to the property owner/manager?  Yes  No If yes, who was it reported to?

Manager/Supervisor Name(If Applicable): \_\_\_\_\_

Date Reported: \_\_\_\_\_ Manager/Supervisor Phone Number: \_\_\_\_\_

Were emergency services called?  Yes  No If yes:  Ambulance  Police  Both

If no, please explain: \_\_\_\_\_

Body parts injured (i.e. low back, right shoulder): \_\_\_\_\_

Please describe how the injury occurred in detail: \_\_\_\_\_

What caused the fall?:  Wet floor  Ice/Snow  Uneven Surface  Loose Rug/Mat  Poor Lighting

Debris/Obstacel  Other: \_\_\_\_\_

Were there any witnesses?  Yes  No

If yes, please describe: \_\_\_\_\_

Please check any difficulties you are experiencing since the incident:

Sitting or Standing for long periods  Walking or climbing stairs  Sleeping

Lifting or carrying objects  Performing work tasks  Other: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Claim #: \_\_\_\_\_ Phone #: \_\_\_\_\_

Adjuster: \_\_\_\_\_ Ext/Direct: \_\_\_\_\_

Adjuster email: \_\_\_\_\_

Attorney Name(if applicable): \_\_\_\_\_ Attorney Phone #: \_\_\_\_\_

Attorney Email: \_\_\_\_\_

Patient Name(Print): \_\_\_\_\_

Patient Signature(X): \_\_\_\_\_ Date: \_\_\_\_\_