Apex Health & Wellness
5110 S. Florida Ave
Lakeland, FL
Slip & Fall Questionnaire

Dear Patient: This information is considered confidential. We need this information to help determine if chiropractic care can help you. If we do not believe your condition will respond, we will not accept your case. For us to understand your whole condition please be neat and accurate as possible while completing this form, Thank you.

Name: _____ Sex: _____ DOB:_____ Phone: _____
Address: _____ City: _____ State: _____ Zip:_____
Occupation: _____ SSN: _____

Date/ Time of injury?
Where did it happen?
What were you doing at the time?
Describe step by step what led up to the injury:
What parts of your body was injured?
Did anything fall on you? ☐ Yes ☐ No If yes, What?
Did you hit your face or head? ☐ Yes ☐ No
Did you lose consciousness? ☐ Yes ☐ No If yes, how long?
Did you see a doctor about this injury? ☐ Yes ☐ No If yes, Who did you see? Where did you go?
Was treatment was given? ☐ Yes ☐ No If yes, please explain.
Has this part of your body been injured before? ☐ Yes ☐ No If yes, When?
Have you lost time from work? ☐ Yes ☐ No If yes, How many days?

Since the injury the symptoms have: ☐ Improved ☐ Worsened ☐ Same

Have you retained an attorney? ☐ Yes ☐ No
If yes, please leave Name, Address & contact number below.

_____
_____
_____

Your Signature: _____