Injury Chiropractor of Spring Hill

3037 Landover Blvd

Spring Hill, FL 34608

Non Auto Accident Questionnaire

Name: _____ Sex:____ DOB:_____

Address:_____

Occupation/Employer:_____ Office Phone #: _____

Place of accident:_____

Address of accident: _____

Date/Time of accident:_____

Did you report the injury (if yes, to whom):_____

Where were you taken after the accident: _____

What are your symptoms?_____

Name of any other doctor consulted since the accident:_____

Treatment Received:_____ How often treated?_____

Did you miss any work? ___Yes or ___No

Dates you missed work:_____

Are your work activities restricted as a result of the accident? ___Yes or __ No

If so, how? _____

Have you ever had any other trauma or accidents? ___ Yes or ___No

Have you ever been previously injured in a similar manner? ___ Yes or ___No

If so, please explain: _____

Do you favor any part of your body in your daily activities because of this accident?

___ Yes or ___No

If so, which part and please explain:_____