Dr. Christopher Sigillo, D.C.

Injury Information

Please fill out the top portion of this questionnaire about your injury then fill-in either the Auto accident column or the Workers Compensation column.

Name: _____
Address: _____
_____
_____
Home: _____
Work: _____

Employer: _____
Address: _____
_____
_____
Your supervisors name: _____
Date of Accident: __/__/__
Location of Accident: _____
Time of Accident: _____

How did the injury happen? _____
_____
_____

Describe your injuries: _____
_____
_____

Have your symptoms been getting worse? ☐ YES ☐ NO

Any witnesses? Who? _____
Were you hospitalized? ☐ YES ☐ NO
If so, what did they do? _____

Have you missed work? ☐ YES ☐ NO

Have you seen any other Doctors? Who? ☐ YES ☐ NO _____
If so, what did they do? _____
_____
Attorney Name: _____
Attorney Phone #: _____

Workers Compensation

Have you notified your boss about your injury? ☐ YES ☐ NO

Have you ever had a similar work injury? ☐ YES ☐ NO

List any activities you have difficulty doing: _____

Are you able to work? ☐ YES ☐ NO

If not, could you perform light duty? ☐ YES ☐ NO

YOUR SIGNATURE: _____
verifying this information

Date: __/__/__

Automobile Accident

Did Police file a report? ☐ YES ☐ NO

Your Auto Insurance Co: _____
Address: _____
_____

Agent Name: _____
Agent Phone #: _____

Policy #: _____
Claim #: _____

Were you the driver? ☐ YES ☐ NO
Any other important information? _____
_____

YOUR SIGNATURE: _____
verifying this information

Date: __/__/__