NORTHWOOD SPORTS MEDICINE
2790 N. Military Trail
West Palm Beach, FL 33409

AUTO ACCIDENT and WORKER'S COMPENSATION QUESTIONAIRE

Name ______________________________ Date ____________

Social Security # ____________________ Phone ____________________

Address ____________________ City ____________ State _____ Zip _______

Age ________ Birth Date ____________ Marital Status M S Sex M F

Occupation ____________________ Employer ____________________

Emloyer's Address ____________________ Phone ____________________

Date and time of accident ____________________ Location ____________

Type of accident ____________ Auto Accident ____________ On the Job ____________ Other

Describe accident in detail ______________________________

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Did you report injury to employer? ______________________________

If auto accident were you ____________ Driver ____________ Passenger

If auto accident were you struck from _____ Behind _____ Front _____ Right Side _____ Left Side

Have you lost any days of work and dates? ______________________________

Have you retained an attorney? ____________ Attorney's Name ____________________

Insurance companies involved:

My company ______________________________

Company of person responsible for injuries ______________________________

Did you consult another Doctor? ________ Doctor's Name ____________________

Were you hospitalized? ____________ Name of Hospital ____________________

Check symptoms you have noticed since accident:

____Headaches
____Neck Pain
____Neck Stiff
____Sleeping Problems
____Back Pain
____Nervousness
____Irritability
____Chest Pain

____Dizziness
____Pins and Needles in Arms
____Pins and Needles in Legs
____Numbness in Fingers
____Numbness in Toes
____Fatigue
____Ears Ringing
____Loss of Balance

Symptoms other than the above ______________________________

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This is confidential information that we will need to file claims and reports on your case.
Please answer all questions as completely as possible.