



Injury Questionnaire

If you are visiting our office as a result of an **auto accident, work related injury**, or other kinds of **injury**, please fill out this questionnaire.

Injury Information	
Name: _____	Today's Date: _____
Type of injury (check all that apply): <input type="checkbox"/> Auto <input type="checkbox"/> Non-Auto <input type="checkbox"/> Sports	
<input type="checkbox"/> On/At work or premise <input type="checkbox"/> Non-work related <input type="checkbox"/> Other explain: _____	

Date of Injury: _____	Area(s) of pain: _____
Claim# _____	Insurance Carrier _____
If injury is work related, is the claim through Washington State Dept of Labor & Industry _____	
If not, then who? _____	
Claim adjuster (if known): _____	Telephone: _____

Injury Description – Please briefly describe how the injury occurred