

Name: _____

DOB: _____

Fall Injury Questionnaire

Date of Fall: _____

What state did you fall in? _____

Where did you fall? _____

Please describe how you fell: _____

Are you planning on filing a personal injury case or lawsuit? YES or NO

If yes, with who: _____

What arm positions make your pain worse? _____

Signature: _____ Date: _____