

DeCrescenzo Chiropractic

Slip & Fall Injury Form

GENERAL INFORMATION

Date: ___ / ___ /20___

Full Name: _____ SS #: _____
First Name Middle Name Last Name

Address: _____
No Street Name Apt.No City State Zip Code

Age: ___ Date of Birth: _____ Sex: Male Female Marital Status: _____

Home Phone: _____ Cell Phone: _____

Work Phone: _____ Email Address: _____@_____.com

Employer: _____ Occupation: _____

Emergency Contact: _____ Relation: _____

Contact Phone: _____

ACCIDENT INFORMATION:

Date of Injury: _____ What state did injury occur? _____

Where did the fall occur? _____

Do you know the insurance information of the responsible party? Yes No

If yes, please list Name, Address and Phone Number of Insurance Company: _____

What were you doing before the accident happened? _____

Did you see the obstacle or condition that caused you to fall? Yes No

Condition of walking surface: Dry Mud Snow/ice covered Wet

Location: Entrance/Exit Hallway Parking Lot Sidewalk/Walkway Stairway/Steps Ramp

Restroom Other: _____

What type of surface did you fall on? _____

Did you fall: Backwards Forward ? On Your: Left Side Right Side ?

From what height did you fall? _____ How many steps did you fall down? _____

Were there any caution signs posted near the accident location? Yes No

Please describe the accident in your own words: _____

PATIENT CONDITION & TREATMENT:

Did you lose consciousness? Yes No If yes, for how long? _____

What were your symptoms following the accident? _____

Did you go to the hospital? Yes No If yes, name of hospital: _____

When did you go? immediately after accident Later that day Next day other: _____

Transported by ambulance? Yes No Do you have any of the following: Cuts Scrapes Bruises

Were x-rays performed? Yes No If yes, which body part? _____

Were any other tests performed? Yes No If yes, what tests? _____

Was medication prescribed? Yes No If yes, what medications? _____

Are you pregnant? Yes No If yes, due date: _____

Do you smoke? Yes No If yes, how much: _____ Drink alcohol? Yes No If yes, how much: _____

SYMPTOMS/INJURIES:

Have you been able to work since this injury? Yes No How many work days have you missed? _____

Please check your symptoms since your injury:

Headaches Neck pain Neck stiffness Jaw problems

left/right Arm pain left/right Shoulder pain left/right Hand/finger pain/numbness

Mid-back pain Back stiffness Chest pain Low back pain

left/right Leg pain left/right Knee/Ankle pain left/right Foot/Toe pain/numbness

Dizziness Nausea Fatigue Sleep difficulty Abdominal pain

Difficulty turning head to the right/left Vision blurred Hearing loss / Balance

Does coughing/sneezing increase your pain? Yes No

Are your symptoms getting worse? Yes No Is it constant or does it come and go? _____

Rate the severity of your pain on a scale from 1 (least pain) to 10 (severe pain) _____

INSURANCE/ATTORNEY INFORMATION:

Insurance Company _____

Claim # _____

Do you have an Attorney? Yes No

If yes, what is his/her name? _____

Do you have health insurance? Yes No

If yes, please give your insurance card to the front desk.

REPORT:

Was this reported to the manager? Yes No

Were there any witnesses? Yes No

Was a report filed? Yes No

If yes, please give the front desk a copy

To the best of my knowledge, the above information is complete and correct. I understand that it is my responsibility to inform my doctor if I, or my minor child, ever have a change in health.

Signature of Patient, Parent, Guardian or Personal Representative

Date

Please print name of Patient, Parent, Guardian or Personal Representative

Relationship to Patient