DeCrescenzo Chiropractic

Slip & Fall Injury Form

GENERAL INFORMATION

Date: ___/____/23____

Full Name: ______________________________ SS #: ____________________
First Name Middle Name Last Name

Address: ____
№ Street Name Apt № 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 Hip 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 (lease pain) to 10 (severe pain) ___________________

Type of pain: □ Sharp □ Cramping □ Dull □ Throbbing □ Burning □ Stabbing □ Grabbing

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 a copy to the front desk

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