# DeCrescenzo Chiropractic

## Slip & Fall Injury Form

### GENERAL INFORMATION

Date: __/__/20__

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