Slip and Fall

Name______________________________DOB__________ DOA__________

Address______________________________ Phone______________

Email______________________________Attorney______________________

□ Male □ Female **Height** ________ **Weight** ________

Are you: □ Right handed □ Left handed □ Ambidextrous (both)

What is your nationality? ____________________

What is your Primary Language: **What is your secondary language:**

Which language do you feel more comfortable speaking?

ACCIDENT DETAILS: (Please circle your answer)

How did you injure yourself? □Slipped on some liquid □Slipped on some gas □Slipped on ice □Slipped on some fresh paint □S

□Tripped on pavement □Tripped on gravel □Tripped on loose object □Tripped on a floor matt □Tripped on wire

Type of business: □Airport □Bank □Bus Station □Casino □Coffee House □Court House □Cruise Ship □Dentist office □Departm

□Lawyers Office □Mall □Marina □Medical Office □Port of Miami □Rail Station □Residence □Restaurant □School

Name of business: ______________________________

Did the manager document the accident? □Yes □No

How did you land? ____

____

In your own words, please explain how the accident happened: ______________________________

____

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Did you lose consciousness at the time of accident? □ Yes □ No

Did police arrive? □ Yes □ No **Was a Police Report taken?** □ Yes □ No

Did you receive medical attention at the scene of the accident? □ Yes □ No

Were you transported to the ER? □ Yes □No If yes, by who: ____________________

Did you seek medical attention after the accident? □ Yes □ No

If yes, where and by whom: ______________________________

Have you seen a Chiropractor since the accident? □ Yes □ No

If yes, what kind of treatment did you have? ______________________________

How many weeks of treatment have you had? __________ How many times a week do you go? __________

How much have you improved since starting treatment? __________%

Were X-rays taken? □Yes □ No Office: __________ **MRI?** □Yes □ No Office: __________

Body part? ______________ **Body part?** ______________

Body Part:	Frequency	Pain Quality Dull/Stabbing/Sharp/	Severity of Pain	Pain Radiation:	Numbness/Tingling

____

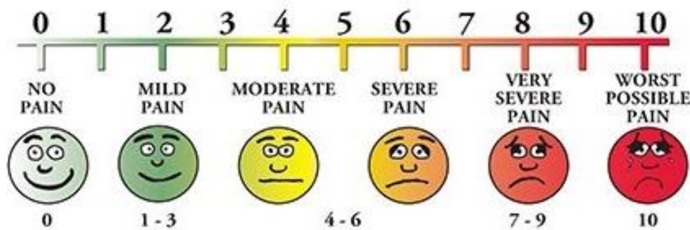
Patient Signature

Mark **ONLY** injured parts	See definitions below:	Throbbing/Aching	Using the pain scale below:	Does your pain radiate anywhere?	Down upper extremities/ lower extremities?
Neck					
Shoulder (L/R)					
Mid Back					
Lower Back					
Knee (L/R)					
Other(s)					

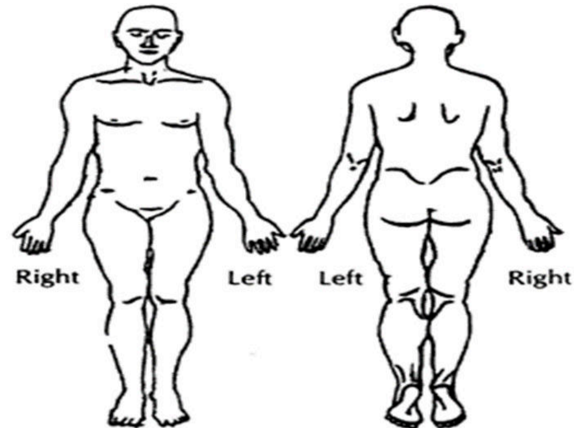
Frequency Definition:

□100% - Continuous □90% - Constant □75% - Frequent □50% - Intermittent □25% - Occasional

↓ Severity of Pain



← Place an X on the body parts you are having pain



Activities of Daily Living:

Sleeping:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	
Bathing:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance
Dressing:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance
Walking:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance
Driving:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance
Cooking:	□No Difficulties	□Some Difficulties	□Moderate Difficulties	□Unable, need assistance

Past Medical History

□Heart Problems □PaceMaker or Stents □High Blood Pressure □Kidney Problems □Thyroid Problems
□Anemia □Diabetes □Seizures □Anxiety/Depression □Osteoporosis □Insomnia □ Stomach/Bowel
□Bleeding Problems/Clotting Problems □High Cholesterol □Headaches □Asthma/Emphysema/Sleep Apnea □ Arthritis
□ Other ________________ □Cancer/History of Cancer (what type) _______________ □NONE OF THE ABOVE

Have you ever had prior surgeries? □Yes □ No

1.Date__________ Procedures________________________ 2.Date__________Procedures______________________

3.Date___________ Procedures_______________________ 4.Date__________ Procedures______________________

Have you had any PAST Accidents ? □Yes □ No **Type of accident** □Motor Vehicle □Slip & Fall □At Work

If yes, **what year?**___________________ **what did you injure**?___________________________________

Did you receive treatment for it? □ Yes □ No If yes, What kind of treatment? _________________________

____
Patient Signature

Prescription Medications/ Over the Counter/ Vitamins ☐N/A

Name of Medication	Dosage (mg)	Times per day

Are you ALLERGIC to any medications? ☐Yes ☐ No

Medication Allergy	Reaction

Are you ALLERGIC to LATEX or RUBBER? ☐ Yes ☐ No **Reaction:** ________________________________

PERSONAL DETAILS:

What is your occupation?	**How long have you been employed there?**
What is your marital status? ☐ Single ☐ Married ☐ Divorced ☐ Widow ☐ Other	
Do you have any children? ☐ Yes ☐ No If yes, How many? __________ **Are you currently pregnant?** ☐ Yes ☐ No If so, how far along are you? _________	
Do you consume any tobacco/nicotine? ☐ Yes ☐ No	
Do you consume Alcohol? Never Socially Occasionally other__________________	
Any use of illicit drugs? ☐Yes ☐No If so, What kind of drugs?	

REVIEW OF SYSTEMS: Please Check All That Apply

General: ☐Fever ☐Chills ☐Loss of Appetite ☐Sleep Disturbance ☐Unexplained Weight Loss/Gain ☐Night Sweats

EENT: ☐Blurry Vision ☐Double Vision ☐Wear Glasses ☐Sore Throat ☐Nasal congestion/Sinus Issues ☐Hearing Loss

Respiratory: ☐Cough ☐COPD ☐Wheezing ☐Recurrent Upper Respiratory Infections ☐Shortness of Breath

Endocrine: ☐Excessive Thirst ☐Temperature Intolerance ☐Feeling Tired/Fatigue ☐Hot Flashes

Cardiovascular: ☐Chest Pain ☐Irregular Heart Beat ☐Heart Attack ☐Heart Failure ☐Palpitations ☐Varicose Veins

Gastrointestinal: ☐Abdominal Pain ☐Nausea/Vomiting ☐Heartburn ☐Blood in Stool ☐Diarrhea/Constipation ☐Rectal Bleeding

Psychological: ☐Depression ☐Anxiety ☐Trouble Concentrating

Hematologic/Lymphatic: ☐Swollen Glands ☐Blood Clotting ☐Easy Bruising ☐Bleeding Tendencies ☐Prone to infections

Genitourinary: ☐Painful Urination ☐Urinary Frequency ☐Loss of Urinary Control ☐Difficulty Urinating

Skin: ☐Skin Rash ☐Itching ☐Lump or Masses ☐Discoloration of the Skin

Musculoskeletal: ☐Joint Pain ☐Joint Swelling ☐Back Pain ☐Limitation of Motion ☐Neck Pain ☐Pain with Walking

Neurological: ☐Tremors ☐Dizzy Spells ☐Numbness/Tingling ☐Headaches ☐Feeling Weak ☐Convulsion/Seizure

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Patient Signature