SLIP & FALL
PATIENT DESCRIPTION

PATIENT INFORMATION

Patient Name: _____ SS#: _____ DOB: _____

Address: _____ City/State: _____ Zip: _____

Phone: _____ Cell: _____ Email: _____

Sex: ____M ____F Marital Status: ___M ___S ___D ___W Spouse Name: _____

Employer: _____ Occupation: _____

Work Phone: _____ Lost Wages? ____Y ____N From _____ to _____

Emergency Contact: _____ Relation: _____ Phone#_____

INJURY INFORMATION

DATE OF INJURY: _____ PLACE OF INJURY: _____ PHONE: _____

INJURIES: _____

Describe what happened:_____

_____

_____

INSURANCE INFORMATION

Insurance Company: _____ Claim#:_____

Adjuster: _____ Phone: _____ Fax: _____

Address: _____ City/State: _____ Zip: _____

Name of Insured/Business: _____ Policy/Incident#:_____

Do you have health insurance? ____Y ____N If yes, Health Insurance Carrier _____

Member Name: _____ Policy#:_____

Group#: _____ ID#: _____

Deductible Met? _____Y _____N

Were you referred to our office? ___Y ___N If so, by whom? _____

Have you been to our office before? ___Y ___N If yes, when? _____

Do you have an Attorney? _____Y _____N If yes, Attorney Name: _____ Phone: _____

SLIP & FALL
INJURY INFORMATION

PATIENT INFORMATION

Today's Date _____

Patient Name _____ SS# _____ DOB _____

DATE OF INJURY _____ Time of Injury _____am/pm

Please describe what happened in your own words _____

_____

_____

_____

INJURY SITE

PLACE OF INJURY _____

Road/Street Name _____

City/State _____

CAUSE OF INJURY

REASON FOR FALL _____

Were you responsible for fall? _____Y _____N

If yes, why? _____

Could fall have been avoided? ____Y ____N

If yes, how:_____

Did you slip or fall due to an item in the store? _____Y _____N

EMERGENCY CARE

INJURIES: _____

_____

_____

Did you lose consciousness? _____Y _____N

Hospital: _____

X-Rays Taken? _____Y _____N

If so, of What _____

MRI Taken? _____Y _____N

If so, of What _____

Surgery performed? _____Y _____N

MANAGER

Did you report fall to store manager? ____Y ____N

Was an injury report filed? ____Y ____N

If yes, Manager Name? _____

Were there any witnesses? ___Y ____N

If yes, Name _____

Phone# _____

Store Insurance Company: _____

PAST HEALTH HISTORY

Previous Illnesses: _____

Previous Injuries or Trauma:_____

Have you ever had any broken bones? ____N ____Y

Previous Surgeries: _____

ALLERGIES: _____

Last Menstrual Cycle: _____

Are you Pregnant? _____Y _____N

PATIENT CONDITION

When did your symptoms appear? ____ Immediately ____Next Day ____Two Days Later ____3 or more days Later

Treatment you have already received for your injury? ____Medication ____Physical Therapy ____Chiropractic Care

Name and Address of Doctor(s) who have treated you for this injury: _____

Medication Prescribed _____

Type of Pain? ____Sharp ____Dull ____Throbbing ____Numbness ____Aching ____Shooting

____Burning ____Tingling ____Cramps ____Stiffness ____Swelling ____Other

How often do you have the pain? _____ Is your Pain? _____ Constant _____Comes and Goes?

What aggravates the pain? _____ What helps the pain? _____

Does pain interfere with your _____Work _____Sleep _____Daily Routine _____Recreation _____School Activities

Activities or movements that are painful: ____Sitting ____Standing ____Walking ____Bending ____Lying Down