Parlopino chiropractic

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Personal Injury Intake Form-Slip and Fall

Name _____ Date _____
Have you missed any days at work? ___ Yes ___No Dates Missed: _____
Date of Accident _____ Time of Accident _____AM/PM
Location of Accident: _____
What did you slip/trip on? _____
Did you fall to the ground? ___ Yes ___No
Did you hit your head? ___ Yes ___No
Did you lose consciousness? ___ Yes ___No For how long? _____
How did you land? _____
Did you sustain any cuts, scrapes, bruises, etc.? ___ Yes ___No
What part of your body? _____
Did anyone witness the fall? ___ Yes ___No
Was a report filed? ___ Yes ___No
With who? _____

Explain in detail how it happened: _____
_____
_____
_____

Were you unconscious after the accident? ___Yes ___No
If yes, for how long? _____
Could you move all parts of your body? ___Yes ___No
If no, which parts couldn't you move and why? _____
_____
Were you able to get up and walk unaided? ___Yes ___No, why not?
_____
Did you get any bleeding cuts? ___Yes ___No If yes, where? _____
_____
Did you get any bruises? ___Yes ___No If yes, where? _____
_____

Please describe how you felt:
1) immediately after the accident? _____
_____

2) Later that day? _____

_____

3) The next day? _____

_____

What makes your pain better? _____

What makes your pain worse? _____

HOSPITALIZATION

Did you go to the hospital immediately after the accident? ___Yes ___No

How did you get there? ___ambulance ___police ___someone drove me ___drove own car

When did you go? ___Immediately after the accident ___Next day ___2 days +

Hospital Name: _____ Name of Doctor: _____

Treatment received: _____

_____

Medications given: _____

_____

X-rays taken: _____

ADDITIONAL TREATMENT

Did you seek any additional treatment? ___Yes ___No

If yes, who did you see? _____

Date of visit? _____ Treatment received: _____

SYMPTOMS

If you have had any of the following symptoms since the accident, please check off:

Rate each symptom with a number on a scale of 0-10 with 10 being the worst.

□ Arm/Shoulder pain	□ Foot/toe numbness	□ Dizziness
□ Low back pain	□ Neck stiffness	□ Ear ringing
□ Neck pain	□ Headaches	□ Memory Loss
□ Upper back pain	□ Irritability	□ Jaw problems
□ Chest pain	□ Nausea	□ Sleep difficulty
□ Leg pain	□ Stomach upset	□ Blurred vision
□ Hand/finger numbness	□ Chest pain	□ Shortness of breath

Past health history: Place an x if it applies and describe:

□ None related to current complaints	□ Hospitalized	□ Surgery
	□ Work Accident	□ Illness
□ Other auto accident(s)		

Describe condition and treatment: _____

_____

_____

_____