ADVANCED
SPINE & POSTURE

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SLIP & FALL

Your Name: _____ Today's Date: __ / __ / ____

Date of Injury: __ / __ / ____ Time of Injury: ____ : ____ (circle one) AM PM

Where were you when this happened? _____

Surface conditions at the time of your injury (Circle One): WET DRY ICY OTHER

Did security or another employee arrive at the scene of your injury (Circle One)? YES NO

Is there a report (Circle One)? YES NO Did you request the report (Circle One)? YES NO

Did you go to the hospital (Circle One)? YES NO If yes, what hospital? _____

How did you get to the hospital/ who transported you (Circle One)? AMBULANCE SELF SPOUSE FRIEND

What parts of your body were x-rayed at the hospital? _____

What did the hospital do for your injuries? _____

If yes, how long did you stay at the hospital? _____

Did you sustain cuts or bleed as a result of this injury? _____

Did you sustain bruises from this injury (Circle One)? YES NO

Did you lose consciousness *'black out'* upon impact (Circle One)? YES NO If yes, how long:_____

Did you experience a flash of light or explosion in your head (Circle One)? YES NO

Did you experience one or more of the following from this injury (Circle all that apply)?

CONFUSED DISORIENTED LIGHTHEADED DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS

Do you still have any of the above symptoms and if so circle which ones (Circle all that apply)?

CONFUSED DISORIENTED LIGHTHEADED DIZZY NAUSEATED BLURRED VISION RING/BUZZ IN EARS

Are you currently experiencing any of the following as a result of this injury (Circle all that apply):

DIFFICULT CONCENTRATING RESTLESSNESS SLEEPLESSNESS CHILLS
REDUCED TOLERANCE TO HEAT DIFFICULTY WITH MEMORY REDUCED
TOLERANCE TO ALCOHOL IRRITABLE FORGETFULNESS

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Did you any of the following body parts get injured (Describe briefly)?

Head Hit _____ Chest Hit _____

Right/Left Shoulder Hit _____ Right/Left Arm Hit _____

Right/Left Hip Hit _____ Right/Left Leg Hit _____

Right/Left Knee Hit_____ Other _____

Were you off work as a result of your injuries (Circle One)? YES NO If yes, from _____ to _____

What type of physical effort is required in your line of work? _____

Does your work aggravate your pain (Circle One)? YES NO SOMEWHAT

Please describe, to the best of your knowledge, what happened during this injury:

_____

_____

_____

_____

_____

_____

_____

_____

Patient Signature:_____ Date: __ / __ / ____