Body Revive Chiropractic
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4132 Katella Ave. Suite 102 Phone: 562-596-9677
Loa Alamitos Ca, 90720 Fax: 562-795-6630

SLIP AND FALL ACCIDENT HISTORY

Date of accident: _____ **Time of accident (approximately):** _____

Location of accident: _____

Description of injury: _____

_____

Were you taken/ did you go to a medical facility? □ Yes □ No

If yes, how did you get there?

_____

Name of hospital/facility: _____

Did you have x-rays/ MRIs/CTs done? □ Yes □ No If yes, what body parts? _____

Were you admitted? □ Yes □ No If yes, date admitted: _____ Date discharged: _____

Describe the accident in your own words:

_____

_____

_____

_____

What were the conditions that caused your accident? (objects, weather, ice/water, etc.

_____

What caused the obstacle or condition (a water leak, broken bottle, raised cement, etc)?

_____

Were you carrying anything in your hands at the time of your fall? _____

How did you land? _____

Did anything fall on you? _____

Did you hit your face or head? □ Yes □ No

Do you have any cuts/bruises? □ Yes □ No If yes, where? _____

Did you lose consciousness? □ Yes □ No If yes, for how long? _____

Did you have any physical complaints BEFORE this accident happened? □ Yes □ No If yes, please explain:_____

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Do you have any congenital (from birth) factors which relate to this problem? □ Yes □ No If yes, please explain:

_____

Have you noticed any activity restrictions because of this accident? □ Yes □ No If yes, please explain:

_____

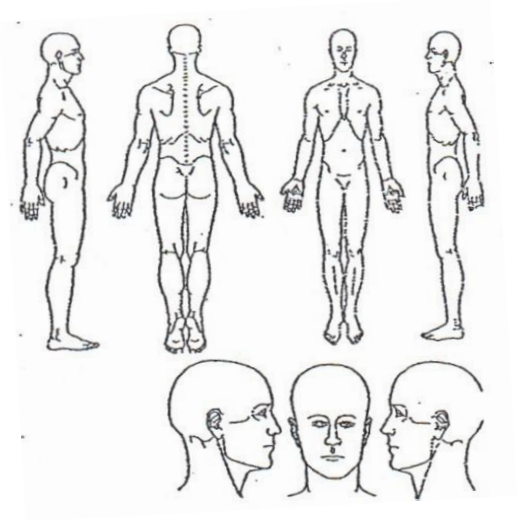
_____

Circle any symptoms you have noticed since the accident (mark all that apply):

Headaches	Pins/needles in arms	Light sensitivity	Fever
Neck pain	Pins/needles in legs	Loss of smell	Cold Sweats
Stiff neck	Numbness in fingers	Loss of taste	Diarrhea
Low back pain	Numbness in toes	Shortness of breath	Constipation
Upper back pain	Cold hands	Dizziness/balance off	Irritability
Shoulder pain	Cold feet	Nervousness	Fatigue
Wrist/Hand pain	Ears ringing	Tension	Fainting
Chest pain	Ears buzzing	Digestive issues	Depression
Elbow pain	Head seems too heavy	Heartburn	Bruises/cuts/scrapes
Ankle/foot pain	Face flushed	Stomach upset	Scars

CURRENT COMPLAINTS:

Circle the areas where you have pain. How often does it occur?



□ Constant 100% □ Frequent 75%

□ Intermittent 50% □ Occasional 25%

What makes symptoms worse?

_____

What gives relief from symptoms?

_____

Type of pain: □ Sharp □ Dull □ Aching □ Burning

□ Throbbing □ Numb □ Other: _____

Have you already seen other doctors for this/ these condition(s)? □ Yes □ No

If yes, what type of doctor(s) have you seen?

_____

Are you presently taking any medications? □ Yes □ No If yes, please list here:

_____

_____

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Have you ever been involved in an accident/injury/slip and fall prior to this one? □ Yes □ No

If yes, what type was it? (Check all that apply) □ Auto □ Work □ Slip & Fall □ Leisure □ Sports □ Other: _____

When? _____

Please provide your health insurance information below. <u>We will also need to make a copy of the front and back of your insurance card, even if you are going through an attorney.</u>

Insurance Company (Aetna, Anthem, etc): _____

Subscriber/Member ID Number: _____

Provider phone number from back of card: _____

Was a claim filed through any type of insurance policy? □ Yes □ No

If yes, please provide their contact info below.

Name of Company: _____

Adjuster Name: _____

Phone Number: _____

Claim Number: _____

Have you retained an attorney? □ Yes □ No

If yes, please provide their contact info below.

Attorney Name: _____

Attorney Address: _____

Attorney Phone Number: _____