Oxford Rehabilitation Center

Slip/Fall Injury Form

Patient Name: _____ Date: _____

Date of Slip Fall accident: _____

Did you fall down steps? **Yes** **NO**

Did you Slip on the floor? Yes NO

If so, what was on the floor? ( ) soap ( ) water ( ) Ice ( ) snow ( ) broken bottle

( ) glass ( ) slippery substance ( ) other _____

Did you Trip? ( ) pallet /skid ( ) box ( ) tool ( ) product ( ) brick ( ) broken floor/tile

( ) broken concrete ( ) raised concrete ( ) curb ( ) manhole ( ) a hole

( ) other _____

When you fell, what body parts did you strike on the ground

( ) landed flat on you back ( ) on your left side ( ) on your right side

( ) your knee: ( )left ( ) right ( )both

( ) your shoulder: ( )left ( ) right

( ) your head ( ) Other _____

Did something fall from the ( ) shelves ( ) ceiling ( ) floor above ( ) Other _____

If something fell from above, did it strike your ( ) head ( ) face ( ) shoulder ( ) arm

( ) elbow ( )hand ( ) back ( ) thigh ( ) knee ( ) leg ( ) foot

Where you bleeding cuts or have bruises?

Yes **NO**

Did you loose Consciousness (asleep or knocked out)

Yes **NO** **NOT SURE**

Immediately following the accident, what symptoms (pain, tingling, burning, dizziness, nausea, cannot hear, trouble breathing, moving a body part or other) did you experience?

_____

_____

Where you unconscious (asleep) immediately after the accident: Yes NO

Due to go to the hospital or urgent care? Yes NO

Name of hospital: _____

Date arrived _____ Date discharge _____

When did you go to the hospital? ( ) Time of the accident ( ) Few hours later ( ) Next day ( ) A number of days later _____.

Patient Name: _____ Date: _____

How did you get to the hospital? ( )Ambulance ( ) Police ( ) Family member

If taken by the ambulance, did they place you in ( ) Cervical collar ( )Backboard ( )Brace ( )Splint

At the hospital were ( )X-rays ( ) CAT scan ( ) MRI ( ) blood work ( ) Urine collected ( ) EKG

If x-rays, CAT scan or MRI taken which body parts: ( )Head ( )Neck ( )Shoulders ( )Arm/elbow/forearm/wrist ( ) Spine ( ) Hip ( ) Thigh/knee/leg/ankle/foot

Did they take blood, urine, culture (open wounds) or sputum (from Lungs) from you?
Yes **NO**

While in the hospital did you have ( )injection ( ) medication ( ) IV (needle in arm with bag of medication)
Arm, elbow, hand or thigh, knee leg, ankle, foot ( )wrapped ( )treated for cuts ( )casted

When you were released from the hospital were you given a prescription for:
( ) Muscle relaxor (parfon forte, cyclobenzaprine, flexerol, soma, Baclofan, Robaxin, Skelaxin, Diazepam _____
( ) Anti-inflammatory (Motrin, ibuprofen, Naprosyn, Celebrex, aspirin _____
( ) Pain medication (percocets, oxycotin, Tylenol, Tramadol, Norco, Vicodin) _____
( ) Nerve medication (gabpentine, Lyrica) _____

If you went to any additional <u>hospitals, urgent care, physicians or treatment centers</u> after the accident please repeat the same questions that you answered above.

Name of hospital, Doctor or Therapy Center: _____

Date arrived _____ Date discharge _____

When did you go to the hospital, Doctor or Therapy Center? ( ) Time of the accident ( ) Few hours later ( )Next day ( ) A number of days later _____ days.

How did you get to the hospital? ( )Ambulance ( ) Police ( ) Family member ( ) other_____

If taken by the ambulance, did they place you in ( ) Cervical collar ( ) Backboard ( ) Brace ( ) Splint

At the hospital were ( )X-rays taken ( ) CAT scan ( ) MRI ( ) blood work ( ) Urine collected ( ) EKG

If x-rays, CAT scan or MRI taken which body parts: ( )Head ( ) Neck ( ) Shoulders ( ) Arm/elbow/forearm/wrist ( ) Spine ( ) Chest/ribs ( ) Hip ( ) Thigh/knee/leg/ankle/foot

Did they take blood, urine, culture (open wounds) or sputum (from Lungs) from you?
Yes **NO**

While in the hospital did you have ( ) injection ( ) medication ( ) IV (needle in arm with bag of medication)
Arm, elbow, hand or thigh, knee leg, ankle, foot ( )wrapped ( )treated for cuts ( )casted

When you were released from the hospital were you given a prescription for:
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( ) Nerve medication (gabpentine, Lyrica) _____

Did you have any physical therapy/chiropractic: ( ) hot packs/cold packs ( ) Exercise ( ) Pool therapy ( ) electric muscle stimulation ( ) ultrasound ( ) paraffin wax ( )massage ( ) Manipulation

Patient Name: _____ Date: _____

Check symptoms/pain/numbness/weakness that you experienced **after this accident**:

( ) Headaches
( ) Neck pain
( ) Shoulder pain ( ) R ( ) L
( ) Arm/Elbow pain ( ) R ( ) L
( ) Hand/wrist pain ( ) R ( ) L
( ) Upper and middle back
( ) Chest pain
( ) Low back pain
( ) Abdomen/stomach
( ) Hip pain ( ) R ( ) L
( ) Knee pain ( ) R ( ) L
( ) Foot/ankle pain ( ) R ( ) L
Burning, tingling, numbness, weakness, PAIN
( ) Radiating to shoulder
( ) Radiating to your hand/fingers
( ) Radiating to hip or buttock
( ) Radiating to thigh
( ) Radiating to leg or feet/toes
( ) Radiating around chest/ribs

( ) Mood changes
( ) Irritability
( ) Nervousness
( ) Increase Menstrual pain
( ) Eyes sensitive to light
( ) Fainting/ Dizziness
( ) Anger issues
( ) Dry Mouth
( ) Loss of sensation to your face
( ) Loss of Smell
( ) Feeling Depressed
( ) Cold feet/hands
( ) Coughing up blood
( ) Blood in Urine
( ) Change in frequent urination
( ) Blurred vision
( ) Loss of balance
( ) Trouble climbing steps
( ) Trouble going down steps

( ) Double vision
( ) Confusion
( ) Difficulty concentrating
( ) Difficulty finding words
( ) Ringing in the ear
( ) Loss of taste-food taste different
( ) Loss of memory
( ) Short term (lost keys)
( ) Long-term (a loved one's name)
( ) Difficulty finding words
( ) Difficulty counting money
( ) Difficulty adding numbers
( ) Nausea
( ) Vomiting
( ) Difficult of falling asleep
( ) awaking at night
( ) Sexual inability
( ) Difficulty holding onto a cup
( ) Tripping over your feet