

SLIP-AND-FALL ACCIDENT FORM

Patient Name: _____ **Date:** _____
 Address: _____ City _____ Zip _____
 Home Telephone: _____ Work Telephone: _____
 Date of Birth: _____ Social Security No: _____

HOW DID YOU FALL?

<input type="checkbox"/> Slippery floor. Describe what was on floor: (water, food, etc) _____	
<input type="checkbox"/> Tripped over object.	
<input type="checkbox"/> Fell down stairs	
<input type="checkbox"/> Fell down fell, did not hit anything. Was able to catch self before landing on floor	
<input type="checkbox"/> Slipped and fell, landing on:	
<input type="checkbox"/> Wood floor	<input type="checkbox"/> Stairs (Circle if wood, concrete or carpet)
<input type="checkbox"/> Carpeted floor	<input type="checkbox"/> Outside pavement/concrete surface
<input type="checkbox"/> Concrete floor	<input type="checkbox"/> Other
<input type="checkbox"/> Off ladder or other structure. How much distance between your body and where you landed _____ feet?	
<input type="checkbox"/> Riding a horse	
<input type="checkbox"/> Other: _____	

DESCRIBE HOW THE FALL HAPPENED

(Include details such as: Why it happened, how did you respond (i.e., hands reached forward), if your body twisted, if you hit the floor/ground, and parts of your body that hit. Indicate if you had bruises.)

WHERE DID YOU HAVE PAIN AND/OR INJURY AFTER THE FALL?

(Circle specific areas after checking area where you have had an increase of pain or had injury in)

<input type="checkbox"/> Head/Face region	<input type="checkbox"/> Left Elbow/Wrist	<input type="checkbox"/> Left Hip/Thigh area
<input type="checkbox"/> Neck area	<input type="checkbox"/> Right Elbow/Wrist	<input type="checkbox"/> Right Hip/Thigh area
<input type="checkbox"/> Middle Back/Chest Wall region	<input type="checkbox"/> Left Hand/Fingers	<input type="checkbox"/> Left Knee/Ankle/Foot/Toe area
<input type="checkbox"/> Left Shoulder/Upper arm area	<input type="checkbox"/> Right Hand/Fingers	<input type="checkbox"/> Right Knee/Ankle/Foot/Toe area
<input type="checkbox"/> Right Shoulder/Upper arm area	<input type="checkbox"/> Low Back/Sacroiliac area	<input type="checkbox"/> Other

H. Edward Camp D.C., C.C.E.P., C.C.S.P., Q.M.E.
 4224 California Street Suite 203
 San Francisco, CA 94118
 (415) 922 2225

BICYCLE ACCIDENT

PATIENT INFORMATION

Patient Name: _____	Date: _____
Address: _____	City _____ Zip _____
Home Telephone: _____	Work Phone: _____ Cell Phone: _____
Date of Birth: _____	Social Security No: _____
Date of injury: _____	Time of injury _____ <input type="checkbox"/> AM <input type="checkbox"/> PM
City where crash occurred: _____	
Street (location) where crash occurred: _____	
Describe the damage to your bicycle? _____	
What were the repair costs for the bicycle? _____	
<input type="checkbox"/> Yes, <input type="checkbox"/> No Did the police come to the accident scene and make a report?	
<input type="checkbox"/> Yes, <input type="checkbox"/> No Were you cited by the police? If yes, name of officer: _____	
<input type="checkbox"/> Yes, <input type="checkbox"/> No Is an attorney currently representing you? If yes, indicate attorney name/address/phone: _____	

DESCRIBE HOW THE BICYCLE CRASH HAPPENED:

ACCIDENT DESCRIPTION (Check all that apply to you)

<input type="checkbox"/> Single-bicycle crash	<input type="checkbox"/> Hit object	<input type="checkbox"/> Hit person
<input type="checkbox"/> Bicycle-to-car/truck crash	<input type="checkbox"/> Hit or attacked by dog	<input type="checkbox"/> Other

HELMET USE

<input type="checkbox"/> Yes <input type="checkbox"/> No Were you wearing a bicycle helmet?
<input type="checkbox"/> Yes <input type="checkbox"/> No Did your helmet break?

ESTIMATED CRASH SPEEDS (If uncertain check the unknown box):

Estimate how fast the other vehicle was moving at time of crash. _____ mph <input type="checkbox"/> Unknown

AT THE TIME OF IMPACT YOUR BICYCLE WAS:

<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining speed
<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at steady speed

AT THE TIME OF IMPACT THE OTHER VEHICLE WAS:

<input type="checkbox"/> Slowing down	<input type="checkbox"/> Gaining Speed
<input type="checkbox"/> Stopped	<input type="checkbox"/> Moving at steady speed

PEDESTRIAN ACCIDENT

PATIENT INFORMATION

Patient Name: _____ Date: _____
Address: _____ City _____ Zip _____
Home Telephone: _____ Work Phone: _____ Cell Phone: _____
Date of Birth: _____ Social Security No: _____
Date of injury: _____ Time of injury _____ AM PM
City where pedestrian injury occurred: _____
Street (location) where injury occurred: _____

Yes, No Did the police come to the accident scene and make a report?
 Yes, No Were you cited by the police? If yes, name of officer: _____
 Yes, No Is an attorney currently representing you? Name/address/phone: _____

DESCRIBE HOW THE PEDESTRIAN INJURY HAPPENED:

INDICATE (CHECK) STREET/CROSSWALK ENVIRONMENT YOU WERE IN:

<input type="checkbox"/>	In marked crosswalk with stop signs
<input type="checkbox"/>	In marked crosswalk with lighted pedestrian signs
<input type="checkbox"/>	In unmarked area of the street. Injury did not occur in marked crosswalk area
<input type="checkbox"/>	Other

AT THE TIME OF IMPACT YOU WERE:

<input type="checkbox"/> Walking	<input type="checkbox"/> Running/Jogging
<input type="checkbox"/> Stopped	<input type="checkbox"/> Other

DESCRIPTION OF VEHICLE THAT HIT YOU:

<input type="checkbox"/> Passenger car	<input type="checkbox"/> Motorcycle	<input type="checkbox"/> Bus
<input type="checkbox"/> Sports Utility Vehicle	<input type="checkbox"/> Bicycle	<input type="checkbox"/> Semi-truck
<input type="checkbox"/> Pick-up Truck	<input type="checkbox"/> Large truck	<input type="checkbox"/> Other

ESTIMATED CRASH SPEED (If uncertain check the unknown box):

Estimate how fast the vehicle was moving at time of impact. _____ mph, Unknown
WHAT IS THE SPEED LIMIT POSTED IN THE AREA WHERE THE INJURY OCCURRED? _____