MID-ATLANTIC
BRAIN & NEUROLOGICAL
REHABILITATION

Accidental Fall Health History

MABNR 1400 Forest Glen Road, Suite 225 • Silver Spring, MD 20910 • Tel (240)-766-8881 Fax (240)-766-3763 • www.mabnr.com

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The Accident

Patient Name: _____

Date of Injury:_____ Approximate Time of Injury: _____

Where were you when you fell?_____

Was this fall:

☐ Sports related ☐ From the stairs ☐ From a curb ☐ From an escalator ☐ Other _____

Did you fall onto a different level from which you were standing? ☐No ☐Yes

Would you describe the mechanism of your fall as involving a:

☐Slip ☐Trip on object ☐ Push ☐ Shove ☐ Struck by an object or person ☐ Other

Please describe how the accidental fall occurred in your own words:

_____

_____

_____

_____

_____

After the accident did you strike anything else? ☐Yes ☐No

If yes, describe:_____

_____

Injuries

Did the police arrive? ☐Yes ☐No If yes, was a report made? ☐No ☐Yes

Were you aware of the accident as it occurred? ☐No ☐Yes

If yes, then did you brace your arms or legs? ☐No ☐Yes

Did you lose consciousness at any point during or after the fall? ☐No ☐Yes

If yes, please explain: _____

What part of your body struck the ground? _____

Please explain: _____

Did your body strike anything else on the way to the ground? ☐No ☐Yes

If yes, please explain: _____

Did you have any pain as a result of the fall? ☐No ☐Yes

If yes, please explain: _____

Did you suffer any bruises, cuts, or broken bones from the fall? ☐No ☐Yes.

If yes, please explain: _____

Did you suffer any of the following symptoms (mark all that apply)?

Dizziness. Light headedness. Severe headache. Vertigo. Blurry vision. Confusion. Memory loss. Extreme drowsiness. Difficulty with focus or concentration. Sensitivity to light. Visual disturbances. Nausea. Vomiting. Muscle weakness. Numbness or tingling. Ringing in ears. Difficulty sleeping. Difficulty with speech. Feelings of depression or sadness. Feelings of nervousness or anxiety. Crying for no reason. Other:_____

Doctor's Notes: _____

Medical History

Did you go to the hospital after the accident? ☐No ☐Yes.

If yes, please answer the five questions below:

1. Did you travel by: ☐Ambulance? ☐Your car? ☐Another car?

2. How long after the accident did you arrive at the hospital?

3. How did you leave the hospital? ☐Someone drove me. ☐I drove myself.

4. Were x-rays or other imaging procedures performed? ☐No ☐Yes
   If yes, explain:_____

5. Did you receive treatment or any prescription/medications at the hospital? ☐No ☐Yes
   If yes, explain:_____

Other than the hospital, have you visited any other health care providers since the accident? ☐No ☐Yes.

If yes, please explain (include names and numbers):_____

Have you ever been involved in an accidental fall before? ☐No ☐Yes

If yes, please answer the five questions below:

1. When and where did the fall(s) occur? a. _____
   If more than 3, please use another sheet of paper b. _____
   c. _____

2. Who did you see for care? a. _____
   If more than 3, please use another sheet of paper b. _____
   c. _____

3. What type of care did you receive? a. _____
   If more than 3, please use another sheet of paper b. _____
   c. _____

Did all of your symptoms resolve from the above mentioned accidental fall(s)? ☐No ☐Yes

If not, what symptoms persisted? Did any remaining symptoms affect your daily activities in any way? ☐No ☐Yes.

If yes, explain:_____

Accidental Fall Health History

Please mark the activities below that have been adversely affected , or are difficult to perform, since your motor vehicle accident.

Domestic Activities

Cleaning	Folding laundry	Moving items	Standing
Cooking	Getting into/out of bed	Lifting objects	Vacuuming
	Holding bowls or cups	Sitting down	Other:

Personal Care Activities

Combing hair	Nail care	Toilet care	Shaving
Brushing teeth	Showering	Bathing	Eating
Applying makeup	Shampooing hair	Dressing	Other:_____

Relationship Activities

Hugging	Laughing	Sexual Activities	Other:_____
Kissing	Holding Hands	Personal Relationships	

Child Care Activities

Carrying your child	Bathing your child	Packing lunch	Pushing a stroller
Changing diapers	Breast feeding	Picking up your child	Toweling after bath
Entertaining your child	Bottle feeding	Playing with your child	Other:_____
	Rocking your child	Hugging your child	

Sports & Athletic Activities

Aerobics	Football	Racquet sports	Table tennis
Archery	Golf	Rafting	Tennis
Baseball	Gymnastics	Rollerblading	Walking
Badminton	Handball	Rock climbing	Waterskiing
Basketball	Horseback riding	Roller skating	Weight training
Biking	Hunting	Rugby	Wind surfing
Boogie boarding	Ice skating	Soccer	Working out
Bowling	Jet skiing	Softball	Wrestling
Camping	Jogging	Snowmobiling	Volleyball
Canoeing	Martial arts	Snowboarding	Yoga
Cross country skiing	Mountain biking	Surfing	Other:_____
Down hill skiing	Pilates	Swimming	

Social Activities

Religious practices	Movies	Shopping	Going out
Picnics	Eating out	Music events / concerts	Reading
Sightseeing	Entertaining	Dancing	Other:_____
Visiting friends/relatives	Vacationing	Walking	

General Household Activities

Mowing the lawn
Fertilizing
Tree trimming
Watering the lawn
Weeding
Yard work
Clearing brush
Raking
Cleaning the gutters
Spraying
Car maintenance
Washing car
Using tools
Painting
Hammering

Activities that Impact Your Career

Attendance at work
Performance at work
Bending activities
Bookkeeping
Communication
Concentration
Data entry
Driving
Fine visual work
Forceful exertion tasks
Grasping actions
Group tasks
Heavy work
Keyboarding
Lifting objects
Machine operation
Memory
Operating a mouse
Prolonged sitting
Prolonged standing
Prolonged walking
Performing required tasks
Pushing actions
Pulling actions
Reaching actions
Reading
Repetitive motion
Safety is affected
Hiking
Speech
Stairs
Telephone operation
Tool operation
Transportation to work
Writing
Working on a computer
Other:_____

General Movement Activities

Movements requiring neck strength or motion
Movements requiring mid back strength or motion
Movements requiring hand strength or motion
Movements requiring elbow strength or motion
Movements requiring hip strength or motion
Movements requiring ankle strength or motion
Movements requiring upper back strength or motion
Movements requiring lower back strength or motion
Movements requiring wrist strength or motion
Movements requiring shoulder strength or motion
Movements requiring knee strength or motion
Movements requiring foot strength or motion

Thank You

for taking the time to fill out this health history questionnaire. This information is important in the doctor obtaining a clinical picture so as to make an appropriate diagnosis & treatment plan. Please sign below authorizing that the information in this form has been read & filled out completely & accurately to the best of your understanding. Also, understand that the information in this form is considered confidential & for use by your doctor. Any disclosure is outlined in our privacy policies.

Patient's signature (*or guardian's signature*): _____

Doctor's Notes: _____

_____

_____

_____

_____

Doctor's Initials: _____

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