

# FIRST AID REPORT FORM

Please fill out the following pieces of information:

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Phone Number: \_\_\_\_\_

What is bothering you the most right now? (**Chief Complaint**):

How did this happen (**History**):

Has this ever happened before?:

**Allergies?** (please list)

Do you have any **Medications?**  
(please list)

Do you have any medical conditions? (please list)

Where is the Pain? \_\_\_\_\_ Describe the Pain \_\_\_\_\_

Is it Radiating? YES NO Rate the pain on a scale of 1 to 10:

When did the pain start? \_\_\_\_\_ Has the pain gotten better? YES NO

	TIME 1: _____ AM/PM	TIME 2: _____ AM/PM
<b>L.O.C.</b>	Alert Verbal = Response Unresp. Pain = Response	Alert Verbal = Response Unresp. Pain = Response
<b>PULSE</b>	Rate: _____ bpm Strong/Weak Regular/Irregular	Rate: _____ bpm Strong/Weak Regular/Irregular
<b>RESPIRATIONS</b>	Rate: _____ bpm Regular / Assisted Deep / Shallow / Gurgling	Rate: _____ bpm Regular / Assisted Deep / Shallow / Gurgling
<b>EYES</b>	Dilated / Pinpoint Equal / Reactive	Dilated / Pinpoint Equal / Reactive
<b>SKIN</b>	Pink Warm Dry Pale Cool Clammy Red Hot Dry	Pink Warm Dry Pale Cool Clammy Red Hot Dry

# HEAD TO TOE

Place an "X" over the injured area

