

PRO PERFORMANCE SPORTS MEDICINE  
CRAIG P RINALDI DC  
13220 NORTH SCOTTSDALE ROAD  
SCOTTSDALE AZ 85254  
T 480 778-9199/F 480 778-9299

**New Patient Registration and Accident Questionnaire**

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Date: \_\_\_\_\_  
                    LAST                    FIRST                    MIDDLE

Address: \_\_\_\_\_ Social Security #: \_\_\_\_\_  Male  Female

City, State, Zip: \_\_\_\_\_ Marital Status:  M  S  W  D # of Children \_\_\_\_\_

Home Phone (\_\_\_\_\_) \_\_\_\_\_ Work Phone (\_\_\_\_\_) \_\_\_\_\_

Cell Phone (\_\_\_\_\_) \_\_\_\_\_ email address: \_\_\_\_\_

Employer: \_\_\_\_\_ Spouse's Name: \_\_\_\_\_

Occupation: \_\_\_\_\_ Spouse's Employer: \_\_\_\_\_

In case of emergency, notify \_\_\_\_\_ Relationship: \_\_\_\_\_ Phone (\_\_\_\_\_) \_\_\_\_\_

Chief Complaint or Reason for Office Visit: \_\_\_\_\_

Specific Date and Time of Onset of Symptoms: \_\_\_\_\_

What makes your symptoms better? \_\_\_\_\_ What makes your symptoms worse? \_\_\_\_\_

What is the quality of your symptoms? (ache, burn, dull, sharp, throbbing): \_\_\_\_\_

Are your symptoms local or do they travel to another area? (If they travel, to where?) \_\_\_\_\_

Are symptoms;  Constant >76%  Frequent 51-75%  Occasional 26-50%  Intermittent <25% of your waking hours

<u>Please list all medications and dosage:</u>	<u>Frequency</u>	<u>For What Illness?</u>
_____		
_____		

List any allergies to medications, foods or other: \_\_\_\_\_

Are you pregnant?  Yes  No First day of last menstrual cycle: \_\_\_\_\_

Do you smoke?  Yes  No; How much? \_\_\_\_\_ Do you drink alcohol?  Yes  No; How much? \_\_\_\_\_

<u>Please list all serious illness and serious accidents:</u>	<u>Month and Year</u>	<u>City, State</u>
_____		
_____		
_____		

<u>Please list any recent x-rays, lab or other tests:</u>	<u>Date</u>	<u>Facility/Doctor</u>
_____		

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Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Accident: \_\_\_\_\_ Hour: \_\_\_\_\_ AM \_\_\_\_\_ PM \_\_\_\_\_

Specific Location of Accident: \_\_\_\_\_

Describe in detail, in your own words, how the accident happened: \_\_\_\_\_

\_\_\_\_\_

In the accident: Were you the  Driver  Passenger  Pedestrian  Other? \_\_\_\_\_

Did your car strike the other vehicle?  Yes  No **Did the other car strike your car?**  Yes  No

Were you struck from:  Behind  Front  Side Impact  Driver's Side  Passenger's Side

Were traffic citations issued to:  You  the Driver of Your Car  the Driver of the Other Car  No Citations Given

Was your car heading:  North  South  East  West on \_\_\_\_\_ (Street/Highway)

Was the other heading:  North  South  East  West on \_\_\_\_\_ (Street/Highway)

**CHECK ANY OF THE FOLLOWING SYMPTOMS YOU HAVE NOTICED SINCE THE ACCIDENT:**

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Headache          | <input type="checkbox"/> Middle Back Pain     | <input type="checkbox"/> Lower Back Pain      | <input type="checkbox"/> Ears Ring       |
| <input type="checkbox"/> Neck Pain         | <input type="checkbox"/> Chest Pain           | <input type="checkbox"/> Lower Back Stiffness | <input type="checkbox"/> Buzzing in Ears |
| <input type="checkbox"/> Neck Stiffness    | <input type="checkbox"/> Bruised Chest        | <input type="checkbox"/> Radiating Pain       | <input type="checkbox"/> Dizziness       |
| <input type="checkbox"/> Sleeping Problems | <input type="checkbox"/> Bruising Anywhere    | <input type="checkbox"/> Tingling in Legs     | <input type="checkbox"/> Loss of Smell   |
| <input type="checkbox"/> Depression        | <input type="checkbox"/> Blurred Vision       | <input type="checkbox"/> Tingling in Arms     | <input type="checkbox"/> Loss of Taste   |
| <input type="checkbox"/> Anxiety           | <input type="checkbox"/> Sensitivity to Light | <input type="checkbox"/> Jaw Pain             | <input type="checkbox"/> Any Burns       |
| <input type="checkbox"/> Fainting          | <input type="checkbox"/> Upper Arm Pain       | <input type="checkbox"/> Upper Leg Pain       | <input type="checkbox"/> Any Stitches    |
| <input type="checkbox"/> Muscle Spasms     | <input type="checkbox"/> Lower Arm Pain       | <input type="checkbox"/> Lower Leg Pain       | <input type="checkbox"/> Any Cuts        |

Other Symptom: \_\_\_\_\_

Have you lost time from work?  Yes  No: If Yes, Dates: \_\_\_\_\_ to \_\_\_\_\_

Where did you go after the accident?  Hospital  Urgent Care  Home  Work  Other \_\_\_\_\_

Were you taken by ambulance?  Yes  No To which hospital? \_\_\_\_\_

Address: \_\_\_\_\_ Date of Hospitalization: \_\_\_\_\_

Attending E.R. Doctor: \_\_\_\_\_ Treatment Given? \_\_\_\_\_

**DO YOU HAVE A HISTORY OF ANY OF THE FOLLOWING DISEASES?:**

- |   |  |  |   |
|---|--|--|---|
| Tuberculosis <input type="checkbox"/> Yes   | Lung Disease <input type="checkbox"/> Yes    | Gout <input type="checkbox"/> Yes            | Diabetes <input type="checkbox"/> Yes   |
| Kidney Disease <input type="checkbox"/> Yes | Stomach/Ulcer <input type="checkbox"/> Yes   | Heart Disease <input type="checkbox"/> Yes   | Hepatitis <input type="checkbox"/> Yes  |
| Sciatica <input type="checkbox"/> Yes       | Blood Pressure <input type="checkbox"/> Yes  | Transfusion <input type="checkbox"/> Yes     | Polio / MS <input type="checkbox"/> Yes |
| Colon Disease <input type="checkbox"/> Yes  | Stroke <input type="checkbox"/> Yes          | Cancer <input type="checkbox"/> Yes          | Bleeding <input type="checkbox"/> Yes   |
| Paralysis <input type="checkbox"/> Yes      | Seizures <input type="checkbox"/> Yes        | Arthritis <input type="checkbox"/> Yes       | Asthma <input type="checkbox"/> Yes     |
| Anemia <input type="checkbox"/> Yes         | Thyroid Disease <input type="checkbox"/> Yes | Drug Dependence <input type="checkbox"/> Yes | AIDS <input type="checkbox"/> Yes       |

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Patient's Name: \_\_\_\_\_ Date: \_\_\_\_\_

**PLEASE PROVIDE US WITH THE APPROPRIATE INSURANCE INFORMATION:**

**1) YOUR AUTOMOBILE INSURANCE CARRIER:** \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: (\_\_\_\_) \_\_\_\_\_ Insured: \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_

Claim Representative: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

Med-Pay Benefits: \_\_\_\_\_ Uninsured (UM) Benefits: \_\_\_\_\_ Underinsured (UIM) Benefits: \_\_\_\_\_

Have you signed a selection waiver of benefits?  Yes  No  Unsure

Are you a full time Student?  Yes  No Do you reside with a relative?  Yes  No

**2) YOUR HEALTH INSURANCE COMPANY:** \_\_\_\_\_

Address: \_\_\_\_\_ Insured: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Policy #: \_\_\_\_\_ SS#: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**3) ADVERSE OR THIRD PARTY AUTOMOBILE INSURANCE CARRIER:** \_\_\_\_\_

Address: \_\_\_\_\_ Claims Rep: \_\_\_\_\_

Claim #: \_\_\_\_\_ Policy #: \_\_\_\_\_ Insured: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**4) ATTORNEY:** \_\_\_\_\_ Legal Assistant: \_\_\_\_\_

Address: \_\_\_\_\_

Telephone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_

**HIPAA Compliance**

Our office is required by law to maintain the HIPAA Notice of Privacy Practices. This notice explains our legal duties and privacy practices with respect to your protected health information. Signature below acknowledges that I have read this Notice of our Privacy Practices. A copy will be provided to me upon request.

Patient Signature: \_\_\_\_\_ Date: \_\_\_\_\_

Witness: \_\_\_\_\_ Date: \_\_\_\_\_

Staff Initials: \_\_\_\_\_