FRAME CHIROPRACTIC

2034 E. Southern Ave, Suite J Tempe, Arizona 85282 Phone: 480.345.2080 Fax: 480.820.5065

∞ W E L C O M E ∞

ABOUT YOU (please print)

Today's Date: _____
Patient Name: _____
DOB: _____ Age: _____ SS#:_____
Mailing Address: _____
City: _____ State: _____ Zip: _____
Home Phone #: _____ Cell Phone #: _____
Work Phone #: _____ EXT #: _____
Minor___ Single___ Married___ Divorced___ Separated___ Widowed___
Spouse's Name: _____
Do you have any children: Yes___ No___ How many: _____
Referred By: _____

Employer: _____
Address: _____
City: _____ State: _____ Zip: _____
Occupation: _____

REASON FOR VISIT (please print)

The reason for this visit is a result of (circle one): **WORK SPORTS AUTO TRAUMA CHRONIC**
(Explain what happened):_____
_____
Explain the pain and location: _____
_____
When did it begin: _____ Is it getting worse: Yes___ No___ Other_____
Is this condition interfering with your: (circle one): **WORK SLEEP DAILY ROUTINE**
If so, please explain: _____
Have you been treated by a Medical Physician for this condition: Yes___ No___
If so, where? _____
Have you ever been treated by a Chiropractor before? Yes___ No____
If so, whom? _____ Phone #: _____

IN THE EVENT OF EMERGENCY(please print)

Who should we contact? _____
Relation: _____
Home Phone #:_____ Cell #:_____
Who is you Medical Doctor? _____ Phone #: _____

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HEALTH HISTORY (please print)

Are you taking any of the following medications?

- ❑ Nerve Pills
- ❑ Pain Killers (including aspirin)
- ❑ Muscle Relaxers
- ❑ Stimulants
- ❑ Tranquilizers
- ❑ Blood Thinners
- ❑ Other_____
  _____
  _____
  _____
  _____
- ❑ Insulin

Do you or have you ever had any of the following conditions (check all that apply)?

❑Heart Attack / Stroke	❑Heart Surg. / Pacemaker	❑Heart Murmur
❑Congenital Heart Defect	❑Mitral Valve Prolapse	❑Hepatitis
❑Alcohol / Drug Abuse	❑Venereal Disease	❑Cancer
❑HIV+ / Aids	❑Shingles	❑Anemia
❑Frequent Neck Pain	❑Emphysema / Glaucoma	❑Rheumatic Fever
❑High/Low Blood Pressure	❑Psychiatric Problems	❑Ulcers / Colitis
❑Severe / Frequent Headaches	❑Kidney Problems	❑Asthma
❑Fainting / Seizures Epilepsy	❑Sinus Problems	❑Chemotherapy
❑Diabetes / Tuberculosis	❑Difficulty Breathing	❑Arthritis
❑Lower Back Problems	❑Artificial Bones / Joints	

Please list any other serious medical condition(s) you have or ever had: _____
_____

List previous surgeries/treatments with dates: _____
_____

List any **past** serious accidents with dates: _____
_____

Family Health History: _____
_____

Do you: Take Supplements or Vitamins? Yes___ No___ Exercise? Yes___ No___
Are you on a special diet: Yes___ No___ Since: _____
Do you smoke? Yes___ No___ How much? _____ How long? _____
Are you wearing: Heels Lifts___ Sole Lifts___ Inner Soles___ Arch Support___
What is the age of your mattress? _____ Is it comfortable? Yes___ No___
For Women: Are you taking Birth Control? Yes___ No___
Are you pregnant? No___ Yes/How Long? _____ Nursing: _____

F R A M E C H I R O P R A C T I C
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AUTO ACCIDENT & INJURY QUESTIONNAIRE

Please Print Clearly

PATIENT'S FULL NAME: _____

Most auto accident injuries can be provided at *no out of pocket cost to you*. However in order **to provide care at no out of pocket cost we need the following information**:

1. ***Your* Automobile Insurance Card**
2. ***Your* Health Insurance Card**
3. **The *Police/Accident Report***
4. **The *other driver's* Name, Address & Auto Insurance Information**
5. **If applicable, *your attorney's* Name, Address & Phone Number.**

YOUR INFORMATION:

Have you contacted your auto mobile insurance company regarding this accident? ▢NO ▢YES
Name of automobile insurance company: _____
Automobile insurance company's address: _____
Automobile insurance company's: (_____) _____
Adjuster's Name: _____
Policy #: _____ Claim #: _____
How are you related to the policy holder? ▢Self ▢Spouse ▢Child ▢Other:
_____
Were you at fault in this accident? ▢NO ▢YES
Was the vehicle involved in the accident yours? ▢NO ▢YES
If not, what is the name and phone number of vehicle owner: _____
_____
Make/Model/Year of vehicle you were in: _____

OTHER DRIVER'S INFORMATION:

Was there another driver/vehicle at fault in this accident? ▢NO ▢YES
Name and Address of driver at fault: _____
_____
Name of their automobile insurance company: _____
Address of their automobile insurance company: _____
Phone number of automobile insurance company: (_____) _____
Name of primary insured on policy, if not driver at fault: _____
Their Policy #: _____ Their Claim #: _____
Their Make/Model/Year of vehicle: _____

WITNESS & ATTORNEY INFORMATION:

Witness Name: _____ Phone: (_____) _____
If applicable, Attorney Name: _____
Address: _____ Phone: (_____) _____
Please notify your attorney that you have chosen Dr. Paul Frame, D.C. & do not wish to be referred elsewhere.

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THE FOLLOWING QUESTIONS WILL HELP US UNDERSTAND HOW THE IMPACT AFFECTED YOU PHYSICALLY/MENTALLY:

Date of auto accident:____/____/____ Time: ___:___ am pm State: ☐AZ ☐Other:_____
Did the police arrive at the scene? ☐NO ☐YES
Did the police issue a ticket? ☐NO ☐YES Who was cited? _____
At what crossroads did the impact occur: _____
Which direction were you traveling? ☐North ☐South ☐East ☐West
Which direction was the other party traveling? ☐North ☐South ☐East ☐West
Was your vehicle hit: ☐From behind ☐In the front ☐Left side ☐Right side
Approximate speed of your vehicle just prior to impact: _____ mph
Approximate speed of the vehicle that hit you: _____ mph
Was anyone with you in the vehicle? ☐NO ☐YES, how many others? _____
Where were you seated? ☐Driver ☐Front Passenger ☐Back Left ☐Back Right
Did the airbag deploy? ☐NO ☐YES ☐My vehicle did not have an airbag
Was your seatbelt? ☐A shoulder harness with lap ☐Lap belt only ☐Off/Not worn
Did your head hit anything? ☐Nothing ☐Steering wheel ☐Windshield ☐Airbag
Did your chest hit anything? ☐Nothing ☐Steering wheel ☐Windshield ☐Airbag
Did your shoulder(s) hit anything? ☐Nothing ☐Steering wheel ☐Windshield ☐Airbag
Did you sustain any: ☐Cuts ☐Bruises ☐Stitches ☐Other: _____
Did you loose consciousness? ☐NO ☐YES
Did the paramedics arrive? ☐NO ☐YES, if so were you treated on site? ☐NO ☐YES
Were you taken to the hospital? ☐NO ☐YES
If yes, were x-rays taken? ☐ NO ☐ YES Date of hospital visit: ____/____/____
If yes, were medications prescribed? ☐ NO ☐ YES List: _____
Name of Hospital: _____ Phone: (_____)_____
Treatment received: _____
Did you see any other doctors for your injuries? ☐NO ☐YES, type of doctor:_____
Name of doctor: _____ Phone: (_____)_____
Treatment received: _____
Do you have any previous illnesses that would relate to this case? ☐ NO ☐ YES
If yes, please describe: _____

Please describe how your BODY FELT and your PHYSICAL CONDITION:
DURING the accident: _____
IMMEDIATELY AFTER the accident: _____
LATER that day: _____
THE NEXT day: _____

In your own words, describe exactly how the accident happened, in detail: _____
_____
_____
_____
_____

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Are you pregnant? ▢ N/A (male) ▢ No ▢ unsure ▢ Yes, Due Date: ____/____/____

CHECK ALL THAT APPLY:

▢ Headaches	▢ Irritability	▢ Numbness in toes	▢ Buzzing in Ears
▢ Neck pain	▢ Chest pain	▢ Shortness in breath	▢ Faced Flushed
▢ Neck stiff	▢ Dizziness	▢ Fatigue	▢ Loss of balance
▢ Upper-back pain	▢ Head seems heavy	▢ Depression	▢ Fainting
▢ Mid-back pain	▢ Sensitivity to light	▢ Loss of taste	▢ Difficulty Sleeping
▢ Low-back pain	▢ Ringing in Ears	▢ Loss of memory	▢ Nervousness
▢ Shoulder pain	▢ Stomach Ache	▢ Pins/Needles in arms	▢ Sleeping problems
▢ Arm Pain	▢ Loss of smell	▢ Pins/Needles in legs	▢ Tension
▢ Leg pain	▢ Visual Weakness	▢ Numbness in fingers	▢ Diarrhea
▢ Cold feet	▢ Constipation	▢ Cold hands	▢ Cold sweats
▢ Fever	▢ Other: _____		

SINCE THIS INJURY OCCURRED, ARE YOUR SYMPTOMS:
▢ Getting Worse ▢ Same ▢ Improving

FAMILY MEDICAL HISTORY: PLEASE CHECK ALL THE APPLY
▢ Cancer ▢ Stroke ▢ Seizures ▢ Diabetes ▢ Abnormal Blood Pressure
▢ Osteoporosis ▢ Cardiovascular Disease

WORK RELATED INFORMATION:
Do you notice any restrictions as a result of this accident? ▢ NO ▢ YES
If yes, describe: _____

Your occupation: _____ ▢ Part-time ▢ Full-time
Have you lost time from work as a result of this injury? ▢ NO ▢ YES
If yes, what dates were you unable to work? ____/____/____ through ____/____/____
Are you being compensated for time lost from work? ▢ NO ▢ YES

By signing below, I hereby certify the above information is complete and accurate to the best of my knowledge. Inaccurate information could be dangerous to my health.

_____ _____ ____/____/____
Signature of Patient/Guardian Print Name Date

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FEE SCHEDULE APPLIED TO ALL INSURANCE COMPANIES

Usual and Customary Fees for Frame Chiropractic

Initial Examination: (1st & 2nd Visits) $60.60-$210.60

Patient conference, detailed review of case history, extended palpatory spinal examination, orthopedic & neurologic examination, correlation of findings. report of radiographic findings, doctor's recommendations, and introduction of care plan.

Intermediate Examination: $60.00-$77.40

A correlation of past and present findings with extended discussion of patient's health as a result of care to date to determine extent and frequency of continued care of dismissal. Includes examination procedures described above.

Spinal X-Rays/2 Views: (when deemed necessary)
$100.00
If radiographic films are taken, law requires all health care facilities to take a minimum of 2 (opposing) views.

Adjustment: $44.40-$73.80

A specific manual (by hand) or instrumental adjustment to correct Subluxations (a misalignment of a spinal/extra spinal joint causing nerve interference).

Heat or Ice Therapy: (as deemed necessary)
$25.00
A pack used for the reduction of muscle spasm and inflammation.

Interferential Current: (as deemed necessary)
$40.00
Electrical stimulation directed to muscles used for the reduction of inflammation.

Manual Therapy: (as deemed necessary)
$65.00
Manual traction therapy for stretching spinal joints/musculature to increase mobility and/or sustained pressure either instrumental or manual for increasing range of motion, reducing muscle spasm, avoiding scar tissue formation, and promotion of the healing process (based on 8-15 minute increments).

Therapeutic Exercise: (as deemed necessary and based on 8-15 minute increments).
$65.00

Patient Name (Printed): _____

Patient Signature: _____

Today's Date: _____ Witness: _____

Dr. Paul E. Frame, D.C.
Frame Chiropractic
2034 E. Southern Ave, Suite J
Tempe, Arizona 85282

PERSONAL INJURY PAYMENT AGREEMENT

If you are injured in an accident and if one or more insurance carriers or any other third party covers your care, we may, at our option, extend full credit once said coverage has been verified. In any event, payments become due as each involved carrier/third party makes them.

By signing below I agree to assign and remit to the doctor all money received by me from Med-Pay (thru my auto insurance), health insurance, third party coverage of any kind as well as from the settlement of any claim or from the payment of any judgment relating to any condition for which the doctor has provided care. ***In no event shall the doctor be entitled to retain more than an amount equal to those charges actually billed for services rendered.***

I hereby appoint the doctor Attorney-in Fact to negotiate and cash any settlement draft or check resulting from charges billed for services rendered and to retain funds sufficient to pay any unpaid balance. The doctor agrees to remit any overpayment directly to me.

I further agree that, should I engage the services of an attorney, I shall immediately notify said counsel of this agreement with specific instructions to acknowledge said notification in writing.

Notwithstanding third party coverage, I understand that I remain fully and solely responsible for all charges incurred for services rendered to me by the doctor or his staff.

I fully understand the terms and conditions relating to payment for services rendered to me. The fee schedule presented with this document has been thoroughly explained to my satisfaction and I accept chiropractic care based on the aforementioned explanations and understandings.

_____ _____

PATIENT SIGNATURE **DATE**

MEDICAL REPORTS AND DOCTOR'S LIEN

If I retain an attorney, I direct my attorney to note ***my doctor of choice*** for accident care:
I authorize and direct said attorney to pay my accident bills to pay my accident bills in full directly to my doctor:

Dr. Paul E. Frame, D.C.
2034 E. Southern Ave, Suite J
Tempe, Arizona 85282
Phone: 480.345.2080 Fax: 480.820.5065
Tax ID: 86-0961762

I hereby authorize and direct my doctor, Dr. Paul E. Frame, D.C. to:

- ✓ Correspond with the attorney representing me in regards to my accident claim.
- ✓ Furnish my attorney with all medical records produced in Dr. Paul E. Frame, D.C. office.
- ✓ Provide my attorney and all insurance companies with extended examination reports, diagnosis, prognosis, daily progress notes, treatment notes, dismissal report, bills, and all records produced in this office prior to or during my care.
- ✓ To file a lien holding all liable parties and carriers responsible for payment.

I hereby authorize and direct you, my attorney, to:

- ✓ Correspond with Dr. Paul E. Frame, D.C. my treating physician, concerning my accident.
- ✓ Inform Dr. Paul E. Frame, D.C. regarding the status of my case.
- ✓ Pay Dr. Paul E. Frame, D.C. directly all sums of money due him for services rendered to me.
- ✓ Forward all medical payments to Dr. Paul E. Frame, D.C. immediately as received.
- ✓ To withhold all sums of money from any settlement, judgment, or verdict as may be necessary to protect Dr. Paul E. Frame, D.C.
- ✓ To pay my accident care in full to Dr. Paul E. Frame, D.C. and issue all checks/drafts to him and to forward all said checks/drafts to his office address above/
- ✓ To honor the recorded lien and my request and make payment(s) to Dr. Paul E. Frame, D.C.

FOR ATTORNEY'S USE ONLY:
The undersigned being attorney of record for the above patient does hereby agree to observe all the terms of the above and agrees to withhold such sums from any settlement, judgment or verdict as may be necessary to protect Dr. Paul E. Frame, D.C.

_____ _____ ____/____/____
Attorney's Signature **Attorney's printed name** **Date**

Please sign, date and return original to doctor's office. Keep a copy for your file.

A photocopy of this document shall be considered as valid as the original.

_____ _____ ____/____/____
Signature of Patient/Guardian Print Name **Date**