

FRAME CHIROPRACTIC

3330 South Price Road, Suite D-110 Tempe, Arizona 85282 Phone: 480.345.2080 Fax: 480.345.2199

∞ 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 your Medical Doctor? _____ Phone #: _____

FRAME CHIROPRACTIC

3330 South Price Road, Suite D-110 Tempe, Arizona 85282 Phone: 480.345.2080 Fax: 480.345.2199

HEALTH HISTORY (please print)

Are you taking any of the following medications?

- | | |
|---|---|
| <input type="checkbox"/> Nerve Pills | <input type="checkbox"/> Blood Thinners |
| <input type="checkbox"/> Pain Killers (including aspirin) | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> Muscle Relaxers | _____ |
| <input type="checkbox"/> Stimulants | _____ |
| <input type="checkbox"/> Tranquilizers | _____ |

Insulin

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

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart Attack / Stroke | <input type="checkbox"/> Heart Surg. / Pacemaker | <input type="checkbox"/> Heart Murmur |
| <input type="checkbox"/> Congenital Heart Defect | <input type="checkbox"/> Mitral Valve Prolapse | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Alcohol / Drug Abuse | <input type="checkbox"/> Venereal Disease | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> HIV+ / Aids | <input type="checkbox"/> Shingles | <input type="checkbox"/> Anemia |
| <input type="checkbox"/> Frequent Neck Pain | <input type="checkbox"/> Emphysema / Glaucoma | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> High/Low Blood Pressure | <input type="checkbox"/> Psychiatric Problems | <input type="checkbox"/> Ulcers / Colitis |
| <input type="checkbox"/> Severe / Frequent Headaches | <input type="checkbox"/> Kidney Problems | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Fainting / Seizures Epilepsy | <input type="checkbox"/> Sinus Problems | <input type="checkbox"/> Chemotherapy |
| <input type="checkbox"/> Diabetes / Tuberculosis | <input type="checkbox"/> Difficulty Breathing | <input type="checkbox"/> Arthritis |
| <input type="checkbox"/> Lower Back Problems | <input type="checkbox"/> 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: _____

FRAME CHIROPRACTIC

3330 South Price Road, Suite D-110, Tempe, Arizona 85201 (480) 345-2080

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.

FRAME CHIROPRACTIC

3330 South Price Road, Suite D-110, Tempe, Arizona 85201 (480) 345-2080

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 lose 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: _____

FRAME CHIROPRACTIC

3330 South Price Road, Suite D-110, Tempe, Arizona 85201 (480) 345-2080

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

CHECK ALL THAT APPLY:

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

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

FRAME CHIROPRACTIC

3330 S. Price Rd. #D-110 Tempe, AZ 85282 Telephone: (480) 345-2080 Fax: (480) 345-2199

FEE SCHEDULE APPLIED TO ALL INSURANCE COMPANIES

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 15 minute increments).

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

Patient Name (Printed): _____

Patient Signature: _____

Today's Date: _____

Witness: _____

**Dr. Paul E. Frame, D.C.
Frame Chiropractic
3330 South Price Road, #D110
Tempe, AZ 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.
3330 South Price Rd, D-110
Tempe, Arizona 85282
Office: 480.345.2080 Fax: 480.345.2199
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