TO: EHLCHE CHIROPRACTIC CLINIC

In consideration of your undertaking to treat me, I agree to the following:

1. You are authorized to release any information concerning my physical condition to any insurance company, attorney or adjuster in order to process my claim for reimbursement of charges incurred for services rendered to me by you or any member of your staff acting in your behalf. It is further agreed, however, that until my account is paid in full or that there is adequate promise of payment that is approved by you, medical records do not have to be sent.

2. I request, authorize and further direct that any insurance company which is obligated to reimburse for services rendered make such payments directly to you. I further direct that all checks should be made payable to you or the clinic, specifically, so that you may obtain immediate payment. Insofar as any payment is concerned, I allow you to stand in my place and receive all payments as they would have been made to me. I further authorize and give my permission to you to endorse any and all checks, drafts, or payments received in my behalf. This authorization is to endorse checks, whether they be received for settlement purposes or services rendered. It is further understood that if at any point the monies received exceed my indebtedness, those funds will be returned to me from your office.

3. I hereby assign and transfer to you any cause of action that exists in my favor against such company (the name(s) of which is believed to be correctly set forth under pertinent data below) and authorize you to prosecute said action, either in my name or in your name, as you see fit. It is agreed, however, that in transferring this cause of action it is agreed between all parties that your interest in this case shall be limited to the amount of the medical bills rendered to me by you or your appointee at any of your clinic facilities. It is further understood and agreed by all parties that the transfer of this cause of action shall not exceed those medical bills that are rendered for my benefit and that are related to the case in question. For the above-named purpose I further authorize and transfer to you my limited power of attorney so that you may act in my behalf in this regard, and in this regard only. It is further understood that until all reasonable efforts have been made to collect sums due from the insurance carriers obligated, you will refrain from attempts to collect amounts from me. I understand whatever amount you do not collect from insurance proceeds, whether it be all or part of what is due, I personally owe you.

I hereby state and agree that this authorization and assignment may not be withdrawn unilaterally.

DATE: ________________________  SIGNED: ________________________

WITNESSED: ________________________  DATE OF INJURY: ________________________

PERTINENT DATA

Names of insurance companies believed to be involved:

My companies: ________________________  Companies of person responsible for accident: ________________________

I hereby state and agree that a photocopy of this document will be deemed as valid and binding on all parties involved.
ASSIGNMENT OF PROCEEDS, LIEN, AND AUTHORIZATION

I HEREBY AUTHORIZE AND DIRECT ANY AND ALL INSURANCE CARRIERS, ATTORNEYS, AGENCIES, GOVERNMENTAL DEPARTMENTS, COMPANIES, INDIVIDUALS, AND/OR OTHER LEGAL ENTITIES ("PAYERS"), WHICH MAY ELECT OR BE OBLIGATED TO PAY, PROVIDE, OR DISTRIBUTE BENEFITS TO ME FOR ANY MEDICAL CONDITIONS, ACCIDENTS, INJURIES, OR ILLNESSES, PAST, PRESENT, OR FUTURE ("CONDITION") TO PAY DIRECTLY AND EXCLUSIVELY TO EHLICH CHIROPRACTIC CLINIC, ECC SUCH SUMS AS MAY BE OWING TO FOR CHARGES INCURRED BY ME AT THE OFFICE RELATING TO MY CONDITION (CHARGES), WITH SUCH PAYMENTS TO BE MADE EXCLUSIVELY IN THE NAME OF EHLICH CHIROPRACTIC CLINIC. I FURTHER GRANT A LIEN TO ECC WITH RESPECT TO MY CHARGES. THIS LIEN SHALL APPLY TO ALL PAYERS AND TO THE FULL EXTENT PERMITTED BY LAW. FOR THE PURPOSES OF THIS DOCUMENT (HEREIN, "ASSIGNMENT AND LIEN"), "BENEFITS" SHALL INCLUDE, BUT NOT BE LIMITED TO, PROCEEDS FROM ANY SETTLEMENT, JUDGEMENT OR VERDICT, AS WELL AS ANY PROCEEDS RELATING TO COMMERCIAL HEALTH OR GROUP INSURANCE, MEDICAL PAYMENTS BENEFITS, PERSONAL INJURY PROTECTION, NO-FAULT COVERAGE, UNDERINSURED MOTORIST COVERAGE, THIRD PARTY LIABILITY DISTRIBUTIONS, DISABILITY BENEFITS, WORKER'S COMPENSATION BENEFITS, AND ANY OTHER BENEFITS OR PROCEEDS PAYABLE TO ME FOR THE PURPOSES STATED.

I AUTHORIZE THIS OFFICE TO RELEASE ANY INFORMATION REGARDING MY TREATMENT OR PERTINENT TO MY CASE(S) TO ALL PAYERS AS DEFINED ABOVE TO FACILITATE COLLECTION UNDER THIS ASSIGNMENT AND LIEN. I FURTHER AUTHORIZE AND DIRECT ALL PAYERS TO RELEASE TO ECC ANY INFORMATION REGARDING ANY COVERAGE OR BENEFITS WHICH I MAY HAVE INCLUDING, BUT NOT LIMITED TO, THE AMOUNT OF THE COVERAGE, THE AMOUNT PAID TO DATE, AND THE AMOUNT OF ANY OUTSTANDING CLAIMS. I HEREBY DIRECT THIS OFFICE TO FILE A COPY OF THIS ASSIGNMENT AND LIEN, TOGETHER WITH ANY APPLICABLE CHARGES, WITH ANY AND ALL PAYERS, REGARDLESS OF WHETHER A CLAIM HAS BEEN ESTABLISHED WITH SAID PAYERS. I HEREBY GRANT ECC POWER OF ATTORNEY TO ENDORSE/SIGN MY NAME ON ANY AND ALL CHECKS LISTING ME AS A PAYEE WHICH ARE PRESENTED TO THIS OFFICE FOR PAYMENT OF AN ACCOUNT RELATING TO ME, MY SPOUSE, OR ANY OF MY DEPENDANTS. I FURTHER AUTHORIZE ECC TO APPLY ANY CREDIT BALANCE ON CHARGES INCURRED BY ME TO ANY OTHER OUTSTANDING CHARGES STILL OWED BY ME, MY SPOUSE, OR MY DEPENDANTS, REGARDLESS OF THESE OTHER CHARGES ARE RELATED TO MY CONDITION.

I UNDERSTAND THAT I REMAIN PERSONALLY RESPONSIBLE FOR THE TOTAL AMOUNTS DUE ECC FOR THEIR SERVICES. THIS ASSIGNMENT AND LIEN DOES NOT CONSTITUTE ANY CONSIDERATION FOR THIS OFFICE TO AVOID PAYMENTS AND IT MAY DEMAND PAYMENTS FROM ME IMMEDIATELY UPON RENDERING SERVICES AT ITS OPTION. IF THIS OFFICE MUST TAKE ANY ACTION TO COLLECT AN OUTSTANDING BALANCE ON MY ACCOUNT, I WILL BE RESPONSIBLE FOR PAYMENT AND WILL REIMBURSE ECC FOR ALL COSTS OF SUCH COLLECTION EFFORTS, INCLUDING, BUT NOT LIMITED TO, ALL COURT COSTS AND ALL ATTORNEY FEES.

THIS ASSIGNMENT AND LIEN SHALL NOT BE MODIFIED OR REVOKED WITHOUT THE MUTUAL WRITTEN CONSENT OF ECC AND MYSELF. I HEREBY REVOCATE ANY PREVIOUSLY SIGNED AUTHORIZATIONS, WHETHER EXECUTED AT THIS OFFICE OR ANY OTHER OFFICE TO THE EXTENT THAT THE TERMS OF THOSE AUTHORIZATIONS CONFLICT WITH THE TERMS OF THIS ASSIGNMENT AND LIEN.

PATIENT NAME (PLEASE PRINT): ___________________________ DATE: __/__/___

PATIENT SIGNATURE: ___________________________ DATE: __/__/___

NAME OF CUSTODIAL PARENT OR LEGAL GUARDIAN (PLEASE PRINT): ___________________________

PARENT/GUARDIAN'S SIGNATURE: ___________________________ DATE: __/__/___
PI ENTRANCE FORM

Visit No: ___________________________ Social Security No: ___________________________

Dominant Hand: Right _______ Left _______ Ambidextrous _______

Patients Full Name: Title: Mr. _______ Mrs. _______ Ms. _______ Miss. _______ Dr. (M) _______ Dr. (F) _______

Last: ___________________________ First: ___________________________ Initial: _______

Date of Birth: ___________________________ Date of Injury/Onset: ___________________________

Date of Current Exam: ___________________________ Date Report Requested: ___________________________

Date Report Written: ___________________________

Case Type: Motor Vehicle Accident _______ Work Comp. _______ Slip & Fall _______

Independent Medical Exam _______ Other _______

Report Type: Initial Narrative _______ Interim Report _______ Final Narrative (No Important Rating) _______

Final Narrative (Impairment Included) _______

Insurance Case No: ___________________________

Policy No: ___________________________ Claim No: ___________________________

Policy holder (if different than patient): ___________________________

FINAL RECIPIENT OF REPORT

Name of Firm or Company: ___________________________

Street Address: ___________________________

Suite, Room, etc. ___________________________ City: ___________________________ State: _______ Zip: _______

ATTN: Mr. _______ Mrs. _______ Ms. _______ Dr. _______ Attorney: ___________________________

First Name: ___________________________ Last Name: ___________________________

Remarks: ___________________________

DESCRIPTION OF ACCIDENT/INJURY/ONSET

Your Vehicle Type: ___________________________

Car _______ Van _______ Bus _______

Station Wagon _______ Pickup _______ Large Truck _______ Other _______

Large Truck _______ Other _______

What was your vehicle doing at the time of accident?

1) Stopped at intersection _______ 2) Stopped in Traffic _______ 3) Stopped at a light _______

4) Making a right turn _______ 5) Making a left turn _______ 6) Parking _______ 7) Accelerating _______

8) Proceeding along _______ 9) Slowing Down _______

Time of Accident: _______ Your Vehicle’s Speed: _______ mph

Their Vehicle’s Speed: _______ mph. Damage to your vehicle: Mild _______ Moderate _______

Totaled _______

Details of Accident:

Visibility at time of Accident: Poor _______ Fair _______ Good _______

Road Conditions: Icy _______ Wet _______ Sandy _______ Dark _______ Clean & Dry _______

Who hit Who/What _______

You hit other vehicle _______

Other vehicle hit you _______

You hit _______

(object) _______
Body Position, etc:
Did you see the accident coming? Y____N____ Were you braced for the impact?
Y____N____ Did you have a seat belt on? Y____N____ Did you have a shoulder harness on?
Y____N____ Did air bag deploy? Driver:Y____N____ Passenger:Y____N____ Side:Y____N____
Does your vehicle have headrests? Y____N____
If yes, what was the position of your headrest at the time of the accident?
Even with top of head ___ Even with bottom of head ___
Middle of Neck ___
What was the direction of your head at the time of the impact?
Facing straight forward ___ Turned to right ___ Turned to left ___
Additional Accident Information: ___

DURING/AFTER ACCIDENT DETAILS
Enter the details of your condition during and after the accident/onset. In the case of a motor vehicle accident, simply check off the applicable options below that best describe the details.

DURING THE ACCIDENT
Did your body strike the inside of your vehicle? Y____N____ If yes, describe ________________

Did you lose consciousness during the injury? Y____N____ How long? _______
Your vehicle’s estimated damages: _______ Damage to their vehicle: Mild ___
Moderate ___ Total ___ Did police show up at the scene? Y____N____
Was an accident report filed? Y____N____
Where did you go after the accident? Home ___ Work ___ ER ___ Private Dr ___
How did you get there? Drove Self ___ Someone else ___ Ambulance ___ Police ___
X-rays done: Y____N____ Was lab work done: Y____N____
Body parts X-rayed: ___ What lab work ___
The X-ray revealed: ___
Treatments: Cervical Collar ___ Ice ___ other ___ Medications ___
Follow up instructions ___

AFTER THE ACCIDENT
Check off your symptoms right after & a few days following
- Headache ___ Neck Pain ___ Neck Stiffness ___ Painting ___ Ringing in ears ___ Loss of smell ___
- Pain behind eyes ___ Dizziness ___ Nausea ___ Confusion ___ Fatigue ___ Tension ___ Irritability ___
- Mid Back Pain ___ Low Back Pain ___ Nervousness ___ Constipation ___ Cold Hands ___ Cold Feet ___
- Diarrhea ___ Depression ___ Anxious ___ Chest Pain ___ Shortness of breath ___ Sleeping Problems ___ Other ___

TREATMENT HISTORY-Fill in any other doctor(s) seen prior to your 1st visit here
1) Dr. ___________________________ 1st visit date ________________
Specialty ___________________________
X-Rays done: Y____N____
Types of Treatments received: ______
How many T x’s received? _______ Currently treating: Y____N____
Did T x’s benefit you? Y____N____ Last visit date: ___________________________
2) Dr. ___________________________ 1st visit date ________________
Types of Treatments received: ______
How many T x’s received? _______ Currently treating? Y____N____
Did T x’s benefit you? Y____N____ Last visit date: ___________________________
LOCATION OF PAIN
1. HEADACHES: Left___Right___Both___
   Front of Head___Top and/or Side___Back of Head___
2. JAW: L____R____B___3. EYE: L____R____B___
4. NECK: L___R___B___5. UPPER BACK: L____R____B___
6. MID BACK: L____R___B___7. LOW BACK: L____R___B___
8. CHEST: L____R___B___9. ABDOMEN: L____R___B___
10. RIBS: L____R___B___11. BUTTOCKS: L____R___B___
12. SHOULDERS: L____R___B___13. UPPER ARMS: L____R___B___
14. FOREARM: L____R___B___15. HAND: L____R___B___
16. HIP: L____R___B___17. LEG: L____R___B___
18. FOOT: L____R___B___19. OTHER LOCATIONS:

IN THE NEXT FOUR SECTIONS, PLEASE PLACE THE # FROM ABOVE OF THE SYMPTOM IN THE SPACE(S) THAT MOST DESCRIBES THE SYMPTOM: ex: neck is #4 — if you have a shooting pain in your neck, then place a 4 next to shooting and any others that may apply.

TYPE OF PAIN
Dull_______Sharp_______Aching_______Cutting_______Throbbing_______Burning_______
Numbing_______Tingling_______Cramping_______Spasm_______Stinging_______
Shooting_______Pounding_______Constricting_______Other_______

PAIN FREQUENCY
Intermittent_______Occasional_______Frequent_______Constant_______

PAIN INTENSITY
Minimal_______Slight_______Moderate_______Marked_______

ACTIONS AFFECTING THIS PAIN
B=Brings on  A=Aggravates  R=Relieves
In the AM: B____A____R____ Loc.#____ In the PM: B____A____R____ Loc.#____
Bending Forward: B____A____R____ Loc.#____
Bending Back: B____A____R____ Loc.#____
Bending Left: B____A____R____ Loc.#____ Bending Right: B____A____R____ Loc.#____
Twisting Left: B____A____R____ Loc.#____ Twisting Right: B____A____R____ Loc.#____
Coughing: B____A____R____ Loc.#____ Sneezing: B____A____R____ Loc.#____
Straining: B____A____R____ Loc.#____ Sitting: B____A____R____ Loc.#____ Lifting: B____A____R____ Loc.#____
Standing: B____A____R____ Loc.#____
Other:______________________________

DOES THIS PAIN RADIATE?
L=Left  R=Right  B=Both
Head: L____R____B___Neck: L____R____B___Shoulder: L____R____B___
Arm: L____R____B___Hand: L____R____B___Hip: L____R____B___
Leg: L____R____B___Foot: L____R____B___Other:______________________________
Rate the patient's current difficulties, with regard to the various activities listed below. Use the following 1-5 scale. Place a number beside the appropriate activity the most closely describes the patient's current degree of difficulty.

1 = "I can do it without any difficulty." 2 = "I can do it without much difficulty, despite some pain." 3 = "I manage to do it by myself, despite marked pain." 4 = "I manage to do it, despite pain, but only if I have help." 5 = "I cannot do it at all, because of the pain."

**Difficulties with Self Care and Personal Hygiene Activities**
- Bathing
- Showering
- Washing Hair
- Drying Hair
- Combing Hair
- Washing Face
- Brushing Teeth
- Making Bed
- Putting on Shirt
- Putting on Shoes
- Tying Shoes
- Pulling on Pants
- Preparing Meals
- Fitting
- Cleaning Dishes
- Taking out trash
- Doing Laundry
- Going to Toilet

**Difficulties with Physical Activities**
- Standing
- Sitting
- Reclining
- Walking
- Stoopiing
- Squatting
- Kneeling
- Reaching
- Bending Forward
- Bending Back
- Bending Left
- Bending Right
- Twisting Back
- Twisting Left
- Twisting Right
- Leaning Back
- Leaning Left
- Leaning right
- Standing for long periods of time
- Sitting for long periods of time
- Walking for long periods of time
- Kneeling for long periods of time

**Difficulties with Functional Activities**
- Carrying small objects
- Carrying large objects
- Carrying brief case
- Carrying large purse
- Lifting weights off floor
- Lifting weights off table
- Climbing stairs
- Climbing inclines
- Pushing things while seated
- Pushing things while standing
- Pulling things with seated
- Pulling things while standing
- Exercising upper body
- Exercising lower body
- Exercising arms
- Exercising legs

**Difficulties with Social and Recreational Activities**
- Bowling
- Jogging
- Swimming
- Golfing
- Dancing
- Skiing
- Ice Skating
- Roller Skating
- Hobbies
- Competitive Sports
- Dating
- Dining out

**Difficulties with Traveling**
- Driving a motor vehicle
- Driving for long period of times
- Riding as a passenger in a motor vehicle
- Riding as a passenger on a train
- Riding as a passenger in a train
- Riding as a passenger for long periods

Use the following 1-5 Scale to describe the difficulties below:

1 = "This area is not affected by my condition." 2 = "This area is slightly affected by my condition." 3 = "My condition moderately restricts my ability in this area." 4 = "My condition seriously limits my ability in this area." 5 = "My condition prevents my from using this ability."

**Difficulty with different forms of communications**
- Concentrating
- Hearing
- Listening
- Speaking
- Reading
- Writing
- Using keyboard

**Difficulty with the Senses**
- Seeing
- Hearing
- Sense of Touch
- Sense of Taste
- Sense of Smell

**Difficulty with hand functions**
- Grasping
- Holding
- Pinching
- Percussive movements
- Sensory discrimination

**Difficulty with Sleep and Sexual Function**
- Being able to have a normal, restful nights sleep
- Being able to participate in desired sexual activity
- Additional information regarding your activities of daily living that wasn't covered above: