DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

STATE OF CALIFORNIA

Within 5 days of your initial examination, for every occupational injury or illness, send this report to **insurer or employer (only if self-insured).** Failure to file a timely doctor's report may result in assessment of a civil penalty. **In the case of diagnosed or suspected pesticide poisoning,** send one copy of this report directly to the Division of Labor Statistics and Research, P.O. Box 603, San Francisco, CA 94101; and notify your local health officer by telephone within 24 hours and by sending a copy of this report within seven days.

1. **INSURER NAME AND ADDRESS**

2. **EMPLOYER NAME**

3. Address: No. and Street City Zip

4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes)

5. **PATIENT NAME** (First name, middle initial, last name)

6. Sex ☐ Male ☐ Female

7. Date of Birth Mo. Day Yr. / /

8. Address: No. and Street City Zip

9. Telephone Number ( )

10. Occupation (Specific job title)

11. Social Security Number - -

12. Injured at: No. and Street City County

13. Date and hour of injury or onset of illness Mo. / Day / Yr. Hour : a.m. : p.m.

14. Date last worked Mo. Day Yr. / /

15. Date and hour of first examination or treatment Mo: / Day / Yr. Hour : a.m. : p.m.

16. Have you (or your office) previously treated patient? ☐ Yes ☐ No

PLEASE DO Nor USE THIS COLUMN: Case No. / Industry / County / Age / Hazard / Disease / Hospitalization / Occupation / Return Date/Code

Patient please complete this portion, if able to do so. Otherwise, doctor please complete immediately. Inability or failure of a patient to complete this portion shall not affect his/her rights to workers' compensation under the California Labor Code.

17. **DESCRIBE HOW THE ACCIDENT OR EXPOSURE HAPPENED** (Give specific object, machinery or chemical. Use reverse side if more space is required.)

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)

A. Physical examination

B. X-ray and laboratory results (State if none or pending.)

20. **DIAGNOSIS** (If occupational illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved ? ☐ Yes ☒ No

1) 3)

2) 4)

21. Are your findings and diagnosis consistent with patient's account of injury or onset of illness? ☒ Yes ☐ No
If no , please explain.

22. Is there any other current condition that will impede or delay patient's recovery? ☐ Yes ☒ No
If yes , please explain.

23. **TREATMENT RENDERED** (Use reverse side if more space is required.)

If further treatment required, specify treatment. Estimated duration

24. If hospitalized as inpatient, give hospital name and location. Date admitted Mo. Dav Yr. / / Estimated stay
N/A

25. **WORK STATUS** Is patient able to perform usual work? ☐ Yes ☐ No
If "no", patient can return to: Mo. Day Yr.
Regular work / /
Modified work / / Specify restrictions

Doctor's Signature ____ Date / / CA License Number ____

Doctor Name and Degree (Please Type) ____ IRS Number 33-0099141

Address 19000 Hawthorne Bl. Suite 302 Torrance CA, 90503 Telephone Number (310) 793-9400

FORM 5021 (Rev. 3)

Any person who makes or causes to be made any knowingly false or fraudulent material statement or material representation for the purpose of obtaining or denying workers' compensation benefits or payments is guilty of a felony

Reorder H.J. Ross Co. (714) 539-2130
B101 Revised 1992

INDUSTRIAL INJURY QUESTIONNARE

(Second Treating/Consulting Doctor Form)

Name: ____ Home Phone #: ________________________
Address: ____ City: ___________________ Zip: _____________
Social Security #: _____ - ____ - _____ CA Driver's License #: ______________________________________
Age: ______ Sex: M F Height: ________ Weight: ________ Cell Phone #: _________________________
Birth Date: __________ Marital Status: M Sep D S W ; Number of Dependent Children: _______
Major Extremity: R L Date of Your Injury: _____________ Approx. Time: ______________AM/PM
Employer at the time of Injury: _______________________________ Occupation: ______________________
Employer's Address: _____________________________________ Office Phone #: ___________________
Are you currently working? Y N ; If not, when was the last day you worked? ___________________
Name of Spouse: ____ Occupation: _______________________
Spouse's Employer: ____ City/Zip: _______________________
Phone #: ____________________ Length of Employment: ____
Do you have an Attorney? Y N ; If so, What is His/Her Name? _______________________________
Attorney's Address: ____ Phone #: _____________________

DESCRIPTION OF INJURY

How did your injury occur?

____
____
____
____
____
____
____
____

Did you report the Injury? Y N ; If so, to whom & when: _____________________________________
Name(s) of Witness(-es), if any: ____
Did your employer refer you to a clinic? Y N ; Clinic Name: ___________________________________

"Right after the injury, my complaint(s) were (from worst to least): ________________________________
____
____
____
____"

Doctor's/Staff Notes:

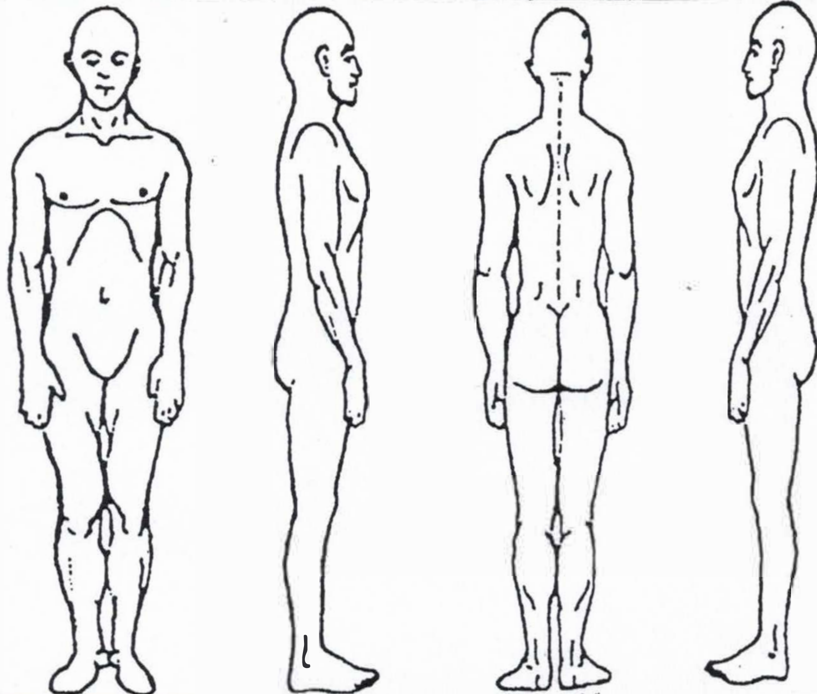
____
____
____
____
____
____
____

F.I.R.S.T. HEALTH

NAME: ____ DATE: ________________

Draw location of your pain on the body outlines using the symbols below to describe your complaint.

Aching	Numbness	Pins & Needles	Burning	Stabbing & Sharp
/\/\/\/\/\	++++++++	0000000000000	XXXXX	//////////////////////////



Instructions: Please choose the number which best describes your pain.

What is your pain RIGHT NOW?

0	0	0	0	0	0	0	0	0	0
1	2	3	4	5	6	7	8	9	10

No Pain Unbearable Pain

PURPOSE OF THIS APPOINTMENT: Please mark "1" if present condition, "2" if past history of.

___Headaches/Migraines
___Neck pain
___Pain between shoulders
___Low back pain/Sciatica
___Spinal check-up for child
___Sports injury
___Auto accident/Whiplash
___Wellness/Prevention care
___Digestive disorder
___Dizziness
___Other____

___Sinuses/Allergy
___Asthma/Allergy
___Ankle/Foot pain
___Wrist/Hand pain
___Nutritional imbalance
___Arthritis
___Numbness
___Rheumatic fever
___Cancer
___Heart trouble

ARE YOU PREGNANT? ___YES ___NO DATE OF LAST MENSTRUAL PERIOD________

SIGNATURE: ____

F.I.R.S.T. HEALTH

HEALTH HISTORY

Who is your primary care physician? ____ Phone #: _____________________

Please check to indicate if you are currently experiencing any of the following conditions:

☐ Arm/Hand Pain	☐ Cold Sweats	☐ Hip Pain	☐ Nausea	☐ Pins/Needles in Legs
☐ Back Pain/Stiffness	☐ Dizziness	☐ Jaw Problems	☐ Neck pain/Stiffness	☐ Sleeping Difficulties
☐ Blurred Vision	☐ Fainting	☐ Leg/Knee Pain	☐ Nervousness	☐ Shoulder Pain
☐ Bowel /Bladder changes	☐ Fever	☐ Light Bothers Eyes	☐ Night Pain	☐ Shortness of breath
☐ Chest Pain	☐ Foot/ Ankle Pain	☐ Loss of Memory	☐ Palpitations	☐ Stomach Problems
☐ Cold Feet	☐ Headaches	☐ Loss of Smell/Taste	☐ Pins/ Needles in Arms	☐ Sudden Weight Loss

Please check to indicate if you have ever had any of the following:

☐ Allergies	☐ Breast Lump(s)	☐ Fractures	☐ Migraines	☐ Psychiatric Care
☐ Allergy Shots	☐ Cancer	☐ Gout	☐ Miscarriage	☐ Sports Injuries
☐ Anorexia/ Bulimia	☐ Chemical Dependency	☐ Heart Disease	☐ Multiple Sclerosis	☐ Stroke
☐ Anemia	☐ Diabetes	☐ Hepatitis	☐ Osteoporosis	☐ Tension
☐ Arthritis	☐ Depression	☐ Hernia	☐ Pacemaker	☐ Thyroid Problems
☐ Asthma	☐ Dysmenohrrea	☐ Herniated Disc	☐ Pinched Nerve	☐ Tuberculosis
☐ Auto Accident Injury	☐ Emphysema	☐ Herpes	☐ Polio	☐ Tumors/Growths
☐ Balance Problems	☐ Epilepsy	☐ Hypertension	☐ Postural Problems	☐ Ulcers
☐ Bleeding Disorder	☐ Fatigue	☐ Kidney Disease	☐ Prostate Problems	☐ Urinary Incontinence
☐ Bowl Disorder	☐ Fibrocystic Breasts	☐ Liver Disease	☐ Prosthesis	☐ Vaginal Infections

☐ Other: ____

Are you currently under medical care? ☐ Yes ☐ No if yes, Explain ________________________________

Please list any medications you are currently taking: ____

____

Please list any surgeries and / or hospitalizations you have had (type & date): ____________________________

____

Please list any allergies: ____

Please list any supplements you are currently taking (vitamins/herbs/minerals): ______________________________

Is there a family history of any of the following conditions? (Indicate family member including parents, grandparents & siblings)

☐ Heart Disease ____________________ ☐ Diabetes __________________

☐ Cancer __________________ ☐ Arthritis ____________________ ☐ Other ____________________

Do you exercise: ☐ Frequently ☐ Moderately ☐ Occasionally ☐ None

Do your work activities mostly involve: ☐ Sitting ☐ Standing ☐ Light Labor ☐ Heavy Labor

Do you sleep on your: ☐ Back ☐ Side ☐ Stomach Do you use a orthopedic pillow? ☐ Yes ☐ No

What is your daily/weekly intake of the following:

Caffeine/Coffee _________ cups/day Alcohol _________ drinks/week Cigarettes ________ packs/day

*I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

SIGNATURE: ______________________________ DATE: ____________________

F.I.R.S.T. HEALTH

CRAIG E. MORRIS, DC
Chiropractic Rehabilitation

THEODORE GEORGIS, MD
Orthopedic Surgery

19000 Hawthorne Blvd. Suite 302
Torrance CA 90503
Phone: (310) 793-9400
Fax: (310) 793-0200

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

To: ____
Name of Doctor, Clinic, Hospital, etc.

____
Address

I ______________________________ request the following information to be released to F.I.R.S.T. HEALTH for the purpose of review:

X-rays _____ History ______ Treatment Records ______ MRI/CT Scan(S) ______ Reports _____

A photocopy of facsimile copy of this form with your signature shall be considered as authentic as the original.

I understand the California Health and Safety Code Section 1795.12 requires the patient records be transmitted within 15 days after receiving this request.

Signed: ______________________________ Date: ________________

____
Translator/ Witness

***CONFIDENTIALLY NOTICE**
THIS FORM IS PRIVILEGED AND CONFIDENTIAL AND IS INTENDED ONLY FOR THE REVIEW OF THE PARTY TO WHOM IT IS ADRESSED. IF YOU HAVE RECEIVED THIS FORM IN ERROR, PLEASE IMMEDIATELY RETURN IT TO THE SENDER.

F.I.R.S.T. HEALTH

19000 Hawthorne Blvd. Suite 302
Torrance, California 90503

INFORMED CONSENT TO CHIROPRACTIC CLINICAL MANAGEMENT

I hereby request and consent to the performance of chiropractic clinical management, including but not limited to, examination, diagnostic x-rays, adjustment and other manual therapeutic methods (treatment by hand or instrument), physiotherapy (modalities such as ultrasound therapy), rehabilitation (exercises and training) and counseling, on me (or on the patient named below, for whom I am legally responsible) by the clinicians, their associates and employees, of the clinic.

Our clinicians employ standard examination methods, which include the following:

1: Observation: general assessment/ appraisal in various positions.
2: Inspection: Viewing/ looking at your body (for bruising, atrophy, swelling, posture, abnormal motion, etc.)
3: Auscultation: Placing a stethoscope on your skin to listen for blood pressure and body sounds.
4: Palpation: The clinician will touch you, feeling for tenderness, heat, swelling, nodules, muscle spasm, misalignment, laxity of tissues, integrity and abnormality.
5: Percussion: Tapping on bones, tendons and other tissues with a rubber reflex hammer or hands/fingers.
6: Orthopedic/ Neurological testing: Standard test to assess your neuromusculoskeletal (i.e. nerves/ muscles/ bones/ joints) system. Some tests may be uncomfortable or painful, especially if you are already in pain.

I understand, and am informed that, as in the practice of medicine, there are some risks to chiropractic treatment including, but not limited to, fracture, disc injuries, strokes, dislocation and sprains. I do not expect the clinician(s) to be able to anticipate and explain all risks and complications, and I wish to reply on the clinician(s) to exercise judgment during the course of the procedure, which the clinician feels at the time, based upon the facts then known, is in my interest.

I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about this consent, and by signing below, I agree to the above named procedures. I
Intend this consent form to cover the entire course of treatment for the present, or any future condition(s) for which I (or my ward named below) seek treatment.

______________________________	______________________________
Print Patient's name	Print Guardian's name
______________________________	______________________________
Signature of Patient	Signature of Guardian
______________________________	______________________________
Witness to Signature	Translator

Date this ______ Day of ____________________________ 20____ Original/File/Patient

F.I.R.S.T. HEALTH

Notice of Privacy Practices

THIS NOTICE DECRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU GET ACESS TO THIS INFORMATION
***PLEASE REVIEW CAREFULLY**

Uses and Disclosures of Protected Health Information

Your protected health information may be used and disclosed by your doctor(s), our office staff and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills, to support the operation of the doctor's practice and any other care required by law

Treatment: Your health information may be used by staff members or disclosed to other health care professionals for the purpose of evaluating your health, diagnosing medical conditions, and providing treatment. For example, we would disclose your protected health information or, as necessary, to a home health agency that provides care to you rand/ or we may share information with hospital staff and other physician or therapist to whom you have been referred to ensure that necessary information is available to diagnose or treat you.

Payment: Your protected health information may be used, as needed, to obtain payment for your healthcare services. For example, obtaining approval for a diagnostic procedure may require that your relevant protected health information be disclosed to the health plan to obtain approval for the procedure.

Healthcare Operation: We may use or disclose as-needed, your protected health information in order to support the business activities of F.I.R.S.T. HEALTH. These activities include, but are not limited to, quality assessment activities, employee review activities, training of clinical staff, licensing, and conducting or arranging for other business activities. In addition, we may use a sign in sheet at the registration desk where you will be asked to sign your name and indicate your physician. We may also call you by name in the waiting room or back office when the doctor or staff is ready to see you. We may use or disclose protected health information, as necessary, to contact you or to remind you of your appointment.

We may use or disclose your protected health information in the following situation without your authorization. These situations include: as required by law, Public Health issues as required by law, Communicable Diseases: Health oversight: Abuse or Neglect: Food and Drug Administration requirements: Legal Proceedings: Law Enforcement: Coroners, Funeral Directions and Organ Donation: Research: Criminal Activity: Military Activity and National Security: Workers Compensation: Inmates: Required Uses and Disclosures: Under the Law (and when required by the Secretary of the Department of Health and Human Services) we must disclose to you any investigations that may involve you to determine our compliance with the requirements of section 164.500

Other Permitted and Required Uses and Disclosure Will Be Made Only With Your Consent, Authorization or Agreement unless require by law.

You may revoke this authorization at any time, in writing, except to the extent that your physician or the physicians practice has taken an action in reliance on the use or disclosures indicated in the authorization. If, in our judgment, the breadth or extension of revoked uses is such that we can no longer adequately provide health care, get paid for our

F.I.R.S.T. HEALTH

services rendered, or conduct our business operations, we may be unable to continue proving Medical/Chiropractic care to you. You do have the right to use another Healthcare Provider.

You have the right to request and copy your protected health information. Under federal law, however, you may not inspect or copy the following records; psychotherapy notes; information compiled in a reasonable anticipation of, a criminal or administrative action proceeding, and protected health information that is subject to law that prohibits access to protected health information.

You have the right to request a restriction of your protected health information. This means you may ask us not to use or disclose any of your protected health information for the purpose of treatment, payment, or healthcare operations. You may also request that any part of your protected health information not be disclosed to family members or friends who may be involved in your care or for notification purposed as described in this Notice of Privacy Practices. Your request must state the specific restriction requested and to whom you want the restriction to apply.

Your physician is not required to agree to a restriction that you may request. If the physician believes it is in your best interest to permit use and disclosure of your protected health information it will not be restricted. You then have the right to use another Healthcare Professional.

You have the right to request and to receive confidential communications from us by alternative means or at an alternative location. You have the right to obtain a paper copy of this notice from us, upon request even if you have agreed to accept this notice alternatively (i.e electronically)

You have the right to receive an accounting of certain disclosures we have made, if any, of your protected health information.

We reserve the right to change the terms of this notice and will inform you of any changes. You then have the right to object or withdraw as provided in this notice

Complaints: You may complain to us or to the Secretary of Health and Human Services if you believe your privacy rights have been violated by us. You may file a complaint with us notifying our privacy officer of your complaint. **We will not retaliate against you for filing a complaint.**

The notice was published and become effective on/or before April 14, 2003

We may require by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protected health information. If you have any objections to this form, please ask to speak with our HIPPA Compliance Officer in person or by phone.

Signature below is only acknowledgement that you have received this notice of our Privacy Practice:

Print Name	Signature	Date

F.I.R.S.T HEALTH
19000 Hawthorne Blvd. Suite 302, Torrance CA, 90503
* Phone (310) 793- 9400 * Fax (310) 793-0200