Absolute Health Chiropractic

Dr. Clay Thomas D.C.

949-589-0526
FAX 949-709-5631

FAX COVER SHEET

DATE: 7.5.18

TO: Natalie Foley FAX: (310) 626-9632 ~~6336~~

FROM: [redacted] PH: 2

RE: Deborah Clarke
Dr's 1st Rpt - don't have all info for form.

2
no. of sheets including cover

STATE OF CALIFORNIA

DOCTOR'S FIRST REPORT OF OCCUPATIONAL INJURY OR ILLNESS

Within 5 days of your initial examination, for every occupational injury or illness, send two copies of this report to the employer's workers' compensation insurance carrier or the insured employer. 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 a copy of the report to Division of Labor Statistics and Research, P.O. Box 420603, San Francisco, CA 94142-0603, and notify your local health officer by telephone within 24 hours.

1. INSURER NAME AND ADDRESS

2. EMPLOYER NAME: CVS Caremark Corp

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): Deborah L. Clarke
6. Sex ☐ Male ☒ Female
7. Date of Birth Mo. Day Yr.: 5.29.49

8. Address: No. and Street City Zip: 30751 El Corazon, RSM, CA 92688
9. Telephone number: 916 705-6658

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 NOT 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.) Pt had previous work injury as was on modified duty when she reinjured her Back + Neck.

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.) Pt has low back pain + neck pain. Pt can only standing 50% of the time + bend 25%.

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination: 9/10 pain level C/S ROM 20/50 Flexion, Extension 20/60, Ⓛ lateral flex 5/45, R lateral 5/45, Ⓛ Rotation 20/80, Ⓡ rotation 10/80 cervical Ext - localized pain. L/ROM Flex 10/60, Ext 10/25, Ⓛ lat 10/25, R lat 10/25, L Straight leg 10°, +SLR
B. X-ray and laboratory results (State if non or pending.)

20. **DIAGNOSIS** (if occupational illness specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ☒ Yes ☐ No
ICD-9 Code M 50.20

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.) E-Stimulation, manual therapy, therapeutic exercise, chiropractic CMT

24. If further treatment required, specify treatment plan/estimated duration. 2-3, 3-4 wks

25. If hospitalized as inpatient, give hospital name and location Date admitted Mo. Day Yr. Estimated stay

26. WORK STATUS -- Is patient able to perform usual work? ☐ Yes ☒ No
If "no", date when patient can return to: Regular work __/__/__ Modified work __/__/__ Specify restrictions: No lifting no standing + no bending

Doctor's Signature: [signature]
CA License Number: DC 30289
Doctor Name and Degree (please type): Doctor of Chiropractic
IRS Number
Address: 29819 Santa Margarita Pkwy, #100 Rancho Santa Margarita, CA 92688
Telephone Number: (949) 589-0526

FORM 5021 (Rev. 4) 1992

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.