CHEELEY CHIROPRACTIC INC.

NEW PATIENT PAPERWORK FOR WORKERS' COMPENSATION

900 East Washington Street, Suite 300 ■ Colton, CA 92324 ■ (909) 888-7649 ■ Fax (909) 888-1955
29099 Hospital Road, Suite 204C ■ Lake Arrowhead, CA 92352 ■ (909) 336-3724 ■ Fax (909) 888-1955
cheeleychiro@cheeleycares.com ■ www.cheeleycares.com

remove obstacles • restore function • improve performance • maximize potential

Welcome to Our Office

We are so glad that you are here today. If you have any questions concerning our policies, forms, or procedures, just ask. It is our pleasure to help you.

Our Privacy Practices

In our office, all health information is considered confidential and we are careful about how we use it. This notice describes how your health information may be used and disclosed and how you can get access to this information. Please read about your health information and let us know if you have any questions.

We may share your health information to:

- Treat you
- Collect payment
- Run our office
- Inform you about other services
- Discuss your case with family
- Do research
- Include you in care classes
- Thank you for referring other patients

We may use your health information for:

- Health and safety reasons
- Reporting to law officials
- Reporting victims of abuse
- Court hearings and filings
- Reporting to worker's compensation

You have the right to:

- Request a copy of your health record
- Request a list of whom we share your health information with
- Ask us to limit the information we share
- Advise our management if you believe your privacy rights have been violated
- Request confidential communications
- Amend your protected health information

These privacy practices are effective: _____

For further information please contact: _____

Consultation & Exam

To begin today's visit, we will collect some confidential health information and then sit and speak with you. After we learn more about your condition, we will perform some preliminary screening tests.

If we believe that we may be able to help you, we will recommend a complete examination so we can thoroughly evaluate your condition.

We will always inform you of associated fees before we perform any procedure or service.

Report of Findings

Patients who are examined will receive a report of our findings from the recorded history, consultation, and examination.

If we believe we can help, we will accept your case at this time. If we believe that you will not respond to our care, we will not accept your case and may refer you to another provider.

Treatment Plan

If we accept your case, we may recommend treatment options based on your unique needs and then an individualized treatment plan may be created to address your short and/or long-term goals.

As you advance through treatment, periodic progress evaluations will measure and compare your improvement.

I understand and agree to the following:

- The privacy practices have been satisfactorily explained to me and I have received a copy of the Notice of Privacy Practices or had an opportunity to receive a copy
- I understand the purpose of today's visit
- The doctor(s) may use my confidential health information in the manner previously described

_____
patient or guardian signature

_____
date

PATIENT INFORMATION FORM

(Office use only)

1)New patient_____ Previous Patient (New Case)_____

Patient Code#_____ 2) Date: ___/___/_____ 3) Time ___:___m 4) Claim#_____

5) First Name: _____M.I. ____ Last Name: _____ 6)Sex: 1) Male 2) Female

7)Birthdate_____/_____/_____ Age_____ Marital Status (S M W D) Spouse's Name_____

8) Social Security # _____/____/_____ 9) Home Phone ( ) ____ - _____ Cell Phone( ) ____ - _____

10) Address _____ City _____ State _____Zip _____

11) Employer _____ 12) Job Title _____ Work Phone ( ) _____- _____

Driver's License No. _____ State: _____

Person Responsible for this account _____

Referred By _____

Primary Insurance: (Group___ Work/Comp ____ Automobile ___ Other ___) 13) Policy # _____

Insurance Co. _____ 14) Group# _____

Address _____ City _____State _____ Zip _____ Phone ( )____-_____

15) Primary name of Insured: _____DOB:____/____/_____ Relationship to Patient _____ SS#_____

16) Employer _____ Employee # _____ Work Phone ( )_____-_____

Work Address_____ City _____ State: _____ Zip_____

Secondary Insurance: (Group___ Work/Comp ____ Automobile ___ Other ___) Policy # _____

Insurance Co. _____ Group# _____

Address _____ City _____State _____ Zip _____ Phone ( )____-_____

Primary name of Insured: _____DOB:____/____/_____ Relationship to Patient _____ SS#_____

Employer _____ Employee # _____ Work Phone ( )_____-_____

Work Address_____ City _____ State: _____ Zip_____

Other Insurance: (Group___ Work/Comp ____ Automobile ___ Other ___) Policy # _____

Insurance Co. _____ Group# _____

Address _____ City _____State _____ Zip _____ Phone ( )____-_____

Primary name of Insured: _____DOB:____/____/_____ Relationship to Patient _____ SS#_____

Employer _____ Employee # _____ Work Phone ( )_____-_____

Work Address_____ City _____ State: _____ Zip_____

Are you or do you think you might be pregnant? 1) Yes 2) No

17) Cause of complaint: (circle) 1) Auto Accident 2) Work Injury 3) Other Accident 4) Illness 5) Congenital 6) Unknown

I Understand and agree that health and accident insurances polices are an arrangement between an insurance carrier and me. I authorize payment for my insurance carrier directly to this office with the understanding that all monies be credited to my account upon receipt. I clearly understand and agree that all services rendered me are charged directly to me and that I am personally responsible for payment. I understand that if I suspend or terminate my care and treatment, all fees for professional services rendered me will be immediately due and payable. In the event of my default, I promise to pay legal interest on the indebtedness together with such collection costs and reasonable attorney's fees as may be required to effect collection.

Patient Signature _____ Date_____/_____/_____

PATIENT HEALTH HISTORY

Name: _____ **Family Physician:** _____

1) FAMILY HISTORY: (Circle as many as apply)

MOTHER: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased- Age at death: _____

FATHER: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

If deceased- Age at death: _____

SIBLINGS: 1) Cancer 2) Diabetes 3) Heart 4) High Blood Pressure 5) Respiratory problems 6) Kidney 7) Stroke 8) In good health

2) SOCIAL HISTORY:

MARITAL STATUS:	1) Single 2) Married 3) Divorced 4) Widowed
NUMBER OF CHILDREN:	(1) (2) (3) (4) (5) (6) (7) (8) (None)
DO YOU:	1) Exercise regularly 2) Eat a balanced diet 3) Obtain sufficient rest
DO YOU SMOKE?	1) No 2) Less than 1 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (packs / day)
DO YOU DRINK COFFEE/TEA?	1) No 2) Occasionally 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (cups / day)
DO YOU DRINK ALCOHOL?	1) No 2) Occasionally 3) 1-2 4) 2-3 5) 3-4 6) More than 5 (drinks / day)

3) MEDICAL HISTORY:

CHILDHOOD ILLNESSES: 1) Measles 2) Mumps 3) Chickenpox 4) Tuberculosis 5) Rheumatic fever 6) Diabetes

LIST ANY SERIOUS CHILDHOOD ILLNESSES NOT RECORDED ABOVE.

_____ Age: [ ]

_____ Age: [ ]

_____ Age: [ ]

LIST ANY BIRTH DEFECTS:

_____

HOSPITALIZATIONS & SURGERIES: If you have ever been hospitalized, list reason and dates.

_____ M/D/Y_____/_____/_____

_____ M/D/Y_____/_____/_____

_____ M/D/Y_____/_____/_____

ADULT ILLNESSES/INJURIES: List all serious diseases & injuries for which you have not been hospitalized; include approximate dates.

_____ M/D/Y_____/_____/_____

_____ M/D/Y_____/_____/_____

_____ M/D/Y_____/_____/_____

4) MEDICATIONS:

List all medications that you are currently taking or have taken on a regular basis in the last 6 months (include home remedies).

A) _____ B) _____

C) _____ D) _____

MEDICATIONS IN WHICH YOU ARE ALLERGIC:

A) _____ B) _____

C) _____ D) _____

PATIENT COMPLAINTS

NAME:_____ A) DATE:_____/_____/_____

B) GENERAL:	Frequency Const/Intermit	Intensity Mild/Moderate/Severe	Pain Type Sharp/Dull
Anxiety	1 2	1 2 3	
Cannot concentrate	1 2	1 2 3	
Nervousness	1 2	1 2 3	
Irritability	1 2	1 2 3	
Fatigue	1 2	1 2 3	
Depression	1 2	1 2 3	
Memory loss	1 2	1 2 3	
Loss of sleep	1 2	1 2 3	
Tension	1 2	1 2 3	
Fainting spells	1 2	1 2 3	
Dizzy spells	1 2	1 2 3	
PMS	1 2	1 2 3	

C) HEAD:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull
Headaches		1 2	1 2 3	1 2
Jaw pain		1 2	1 2 3	1 2
Jaw tension		1 2	1 2 3	
Pain in ears	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Ringing in ears		1 2	1 2 3	
Ear discharge	Lt.	1 2	1 2 3	
	Rt.	1 2	1 2 3	
Hearing loss	Lt.		1 2 3	
	Rt.		1 2 3	
Eye pain	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Decreased acuity			1 2 3	
Light sensitivity			1 2 3	
Floating lights			1 2 3	
Nose bleeds			1 2 3	
Nasal obstruction			1 2 3	

D) NECK/THROAT:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull
Neck pain	Lt.	1 2	1 2 3	1 2
	Diffuse	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Pain radiates to	Lt.	1)Shldr 2)Arm	3)Elbw 4)Wrist	5)Fingers
	Rt.	1)Shldr 2)Arm	3)Elbw 4)Wrist	5)Fingers
Stiffness		1 2	1 2 3	
Grinding sounds		1 2	1 2 3	
Popping sounds		1 2	1 2 3	
Hoarseness		1 2	1 2 3	

E) SHOULDERS:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull
Pain with motion	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Pain at rest	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Muscle spasm	Lt.	1 2	1 2 3	
	Rt.	1 2	1 2 3	
Limited motion	Lt.	1 2	1 2 3	
	Rt.	1 2	1 2 3	
Muscle weakness	Lt.	1 2	1 2 3	
	Rt.	1 2	1 2 3	

F) ARMS:		Frequency Const/Intermit	Intensity Mild/Moderate/Severe	Pain Type Sharp/Dull
UPPER ARM pain	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Pins & Needles	Lt.	1 2	1 2 3	
(upper arm)	Rt.	1 2	1 2 3	
Numbness	Lt.	1 2	1 2 3	
(upper arm)	Rt.	1 2	1 2 3	
Muscle weakness	Lt.	1 2	1 2 3	
	Rt.	1 2	1 2 3	
ELBOW pain	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
FOREARM pain	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Pins & Needles	Lt.	1 2	1 2 3	
(forearm)	Rt.	1 2	1 2 3	
Numbness	Lt.	1 2	1 2 3	
(forearm)	Rt.	1 2	1 2 3	
Muscle weakness	Lt.	1 2	1 2 3	
	Rt.	1 2	1 2 3	

G) HANDS:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull
Wrist pain	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Hand pain	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Pins & Needles	Lt.	1 2	1 2 3	
	Rt.	1 2	1 2 3	
Numbness - hand	Lt.	1 2	1 2 3	
	Rt.	1 2	1 2 3	
Thumb pain	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Index finger pain	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Middle finger pain	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Ring finger pain	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Little finger pain	Lt.	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Numbness - fngr	Lt.	1)Index 2)Middle	3)Ring 4)Little	5)Thumb
	Rt.	1)Index 2)Middle	3)Ring 4)Little	5)Thumb
Muscle weakness	Lt.	1 2	1 2 3	
	Rt.	1 2	1 2 3	

H) MIDBACK:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull
Pain	Lt.	1 2	1 2 3	1 2
	MIDLINE	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Muscle spasm	Lt.	1 2	1 2 3	
	Rt.	1 2	1 2 3	

I) LOWBACK:		Const/Intermit	Mild/Moderate/Severe	Sharp/Dull
Pain	Lt.	1 2	1 2 3	1 2
	MIDLINE	1 2	1 2 3	1 2
	Rt.	1 2	1 2 3	1 2
Stiffness		1 2	1 2 3	
Muscle spasm	Lt.	1 2	1 2 3	
	Rt.	1 2	1 2 3	
Pain radiates to	Lt.	1)Buttocks 2)Hip	3)Side of Leg	4)Back of Leg
	Rt.	1)Buttocks 2)Hip	3)Side of Leg	4)Back of Leg

J) PELVIS:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Hip joint pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Sacroiliac pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Buttock pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Groin pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Tail bone pain		1	2	1	2	3	1	2

K) THIGH:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pain radiates to	Lt.	1)Knee___		2)Calf___		3)Ankle___		
	Rt.	1)Knee___		2)Calf___		3)Ankle___		
Numbness	Lt.	1	2	1	2	3		
Pins and Needles	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Knee pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Swollen knee	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Muscle weakness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

L) CALVES		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Calf Pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pain radiates to	Lt.	1)Ankle___		2)Foot___		3)Toes___		
	Rt.	1)Ankle___		2)Foot___		3)Toes___		
Numbness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Pins and Needles	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Cramps	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Muscle weakness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

M) ANKLES:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Swelling	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		

N) FEET:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Numbness	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Pin and Needles	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Swelling	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Cramps	Lt.	1	2	1	2	3		
	Rt.	1	2	1	2	3		
Big toe pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
2nd toe pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Mid toe pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
4th toe pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Small toe pain	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2

O) CHEST:		Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Deep chest pain		1	2	1	2	3	1	2
Pain around ribs	Lt.	1	2	1	2	3	1	2
	Rt.	1	2	1	2	3	1	2
Pain with exertion		1	2	1	2	3	1	2
Shortness of breath		1	2	1	2	3		
Difficult breathing		1	2	1	2	3		
Irregular heartbeat		1	2	1	2	3		
Rapid heart beat		1	2	1	2	3		
Night sweats		1	2	1	2	3		
Chronic cough		1	2	1	2	3		

P) DIGESTIVE TRACT:	Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Stomach pain	1	2	1	2	3	1	2
Indigestion	1	2	1	2	3		
Nausea	1	2	1	2	3		
Gas	1	2	1	2	3		
Clay colored stool	1	2	1	2	3		
Black tarry stool	1	2	1	2	3		
Hemorrhoids	1	2	1	2	3		
Bleeding from rectum	1	2	1	2	3		
Abnormal weight loss			1	2	3		
Diarrhea	1	2	1	2	3		
Constipation	1	2	1	2	3		

Q) URINARY TRACT:	Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Painful urination	1	2	1	2	3	1	2
Frequent urination	1	2	1	2	3		
Unable to urinate	1	2	1	2	3		
Leakage of urine	1	2	1	2	3		
Blood in urine	1	2	1	2	3		
Bedwetting	1	2	1	2	3		

R) WOMEN ONLY:	Const/Intermit		Mild/Moderate/Severe			Sharp/Dull	
Painful menstruation	1	2	1	2	3	1	2
Excess menstruation	1	2	1	2	3		
Missed periods	1	2	1	2	3		

S) SUMMARY:

You have identified general complaints and complaints in different parts of your body. Enter the letter (B thru R) to tell us where:

1) Is your most serious complaint. _____

2) Is your next most serious complaint. _____

3) Approximate date of onset (if known): ____/____/____

4) Onset was: 1) Sudden 2) Gradual

5) Are the complaints? (circle one)
1) Improving 2) Getting worse
3) About the same 4) Intermittent (Comes & Goes)

6) When are the complaints most noticeable?
1) Morning 2) Afternoon 3) Evening 4) Night

7) What aggravates the complaint(s)?
1) Standing 2) Walking 3) Sitting 4) Bending
5) Lying 6) Lifting 7) Twisting 8) Coughing

8) What relieves the complaint(s)?
1) Rest 2) Sitting 3) Lying 4) Bending
5) Stretching 6) Exercise 7) Lying knees bent

INDUSTRIAL INJURY QUESTIONNAIRE

WCAB #: _____

Name: _____ Tx. Approved by: _____

If you are represented by an attorney for this claim, complete the following:
Attorney Name: _____ Phone ( ) _____-_____
Address_____ City _____ State _____ Zip_____

1) Date and time of accident or date and time symptoms first appeared: Date: _____/_____/_____ **Time :** _____:_____ (AM/PM)
2) Cause of trauma: 1) Accident 2) Gradual Onset **3) Name of employer at time of injury:** _____
4) Employer's street address: _____ **City:** _____
County: _____ **State:** _____ **Zip:** _____ Phone # ( ) _____-_____
5) Your job title at the time of the injury: _____ **6) Nature of business:** _____
7) Do you consider you job: 1) Undemanding 2) Rewarding 3) Enjoyable 4) Strenuous 5) Demanding 6) Stressful
8) How long have you been employed, at this job title, with this company? _____years _____ months
9) Last day worked: _____/_____/_____ **10) Date you returned to modified work.** _____/_____/_____
11) Returned to work. _____/_____/_____ **12) Are you working now?** 1) Yes, part time 2) Yes, full time 3) No
Receive Temp. Total Disability? (Yes) (No) Date began: ____/____/____ State disability? (Yes) (No) Date began: ____/____/____
13) I am: 1) able to perform usual work. 2) able to perform light work only. 3) not able to work at all.

14) Describe any p-re-existing conditions, disabilities, or restrictions:
A) _____ **Onset:** _____/_____/_____
Cause:1) Auto accident 2) Work injury 3) Sports injury 4) Injury at home 5) Other injury 6) Illness 7) Congenital 8) Unknown cause
B) _____ **Onset:** _____/_____/_____
Cause:1) Auto accident 2) Work injury 3) Sports injury 4) Injury at home 5) Other injury 6) Illness 7) Congenital 8) Unknown cause
C) _____ **Onset:** _____/_____/_____
Cause:1) Auto accident 2) Work injury 3) Sports injury 4) Injury at home 5) Other injury 6) Illness 7) Congenital 8) Unknown cause

15) Where did the accident occur? 1) On the job at the address above 2) On the job at another location 3) On the job in vehicle
16) If not at the address listed above: Address: _____
City _____ County _____ State _____ Zip _____
NOTE: If Vehicle Accident, Complete Vehicle Acc. Form!

17) In you own words, describe how the accident happened (be specific):
_____
_____
_____

18) Were you unconscious? 1) No 2) Not sure, how long 3) A few seconds 4) A few minutes 5) An hour 6) A few hours
19) After the accident, did you feel? (circle as many as apply)
1) Stunned 2) Frightened 3) Confused 4) Dazed 5) Dizzy 6) Shocked 7) Shaken 8) Nauseous
20) Did you receive medical aid at accident site? 1) Yes 2) No
21) Where did you go right after the accident?
1) Hospital 2) Emergency center 3) Home 4) Family physician 5) To this office 6) Resumed activities 7) Work
22) How did you get there? 1) Ambulance 2) Drove myself 3) Someone drove me 4) Walked
23) Did your symptoms develop:
1) Immediately 2) Hours later 3) Next day 4) Over few days 5) During first week 6) Over a few wks 7) Over a few mos

If you were treated by another Doctor or Therapist for this condition, answer questions 24- 26:

24) Name: _____ 1) CA 2) DC 3) DDS 4) DO 5) DPM 6) MD 7) OD 8) PT *
B) Tests Performed: 1) Exam 2) X-ray 3) CAT scan 4) EMG 5) Thermography 6) MRI 7) EEG 8) Lab 9) Psychological
C) Prescription received: 1) Pain killers 2) Muscle Relaxants 3) Antibiotics 4) Sedatives 5) Anti-Inflammatory 6) Other
D) Treatment frequency: 1) Daily 2) 1x a week 3) 2x a week 4) 3x a week 5) 4x a week
6) 1x a month 7) 2x a month 8) 3x a month
E) Treatment duration: was _____ (circle) 1) Day(s) 2) Week(s) 3) Month(s)
F) Date first appointment: _____/_____/_____ **G) Date last appointment:** _____/_____/_____
H) Did Treatment Help? 1) No, Aggravated the condition 2) No 3) Yes, a little 4) Yes, a lot 5) Cured the condition

25) Name: _____ 1) CA 2) DC 3) DDS 4) DO 5) DPM 6) MD 7) OD 8) PT *
B) Tests Performed: 1) Exam 2) X-ray 3) CAT scan 4) EMG 5) Thermography 6) MRI 7) EEG 8) Lab 9) Psychological
C) Prescription received: 1) Pain killers 2) Muscle Relaxants 3) Antibiotics 4) Sedatives 5) Anti-Inflammatory 6) Other
D) Treatment frequency: 1) Daily 2) 1x a week 3) 2x a week 4) 3x a week 5) 4x a week
6) 1x a month 7) 2x a month 8) 3x a month
E) Treatment duration: was _____ (circle) 1) Day(s) 2) Week(s) 3) Month(s)
F) Date first appointment: _____/_____/_____ **G) Date last appointment:** _____/_____/_____
H) Did Treatment Help? 1) No, Aggravated the condition 2) No 3) Yes, a little 4) Yes, a lot 5) Cured the condition

26) Name: _____ 1) CA 2) DC 3) DDS 4) DO 5) DPM 6) MD 7) OD 8) PT *

B) Tests Performed: 1) Exam 2) X-ray 3) CAT scan 4) EMG 5) Thermography 6) MRI 7) EEG 8) Lab 9) Psychological

C) Prescription received: 1) Pain killers 2) Muscle Relaxants 3) Antibiotics 4) Sedatives 5) Anti-Inflammatory 6) Other

D) Treatment frequency: 1) Daily 2) 1x a week 3) 2x a week 4) 3x a week 5) 4x a week 6) 1x a month 7) 2x a month 8) 3x a month

E) Treatment duration: was _____ (circle) 1) Day(s) 2) Week(s) 3) Month(s)

F) Date first appointment: _____/_____/_____ **G) Date last appointment:** _____/_____/_____

H) Did Treatment Help? 1) No, Aggravated the condition 2) No 3) Yes, a little 4) Yes, a lot 5) Cured the condition

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27) My usual work schedule is:_____ hours per day: (1) (2) (3) (4) (5) (6) (7) days / wk.

28) Do you use your hands for repetitive movements such as: (Circle all that apply)

Left Hand: 1) Light grasp 2) Firm grasp 3) Fine movements

Right Hand: 4) Light grasp 5) Firm grasp 6) Fine movements

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29) In a typical workday, I:

A) Sit	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
B) Stand	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
C) Walk	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
D) Crawl	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
E) Climb	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
F) Drive	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
G) Balance	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
H) Crouch	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
I) Kneel	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
J) Squat	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
K) Bend / Stoop	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
L) Bend while lifting	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
M) Reach above shoulder	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
N) Push / Pull	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day

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30) At work, if exposed to any of the following, circle the hours per day of exposure:

A) Dust	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
B) Lint	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
C) Toxic chemicals	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
D) Gases	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
E) Moving machinery	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
F) Unprotected heights	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
G) Loud noises	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
H) Hazardous environment	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day
I) Mental stress	(1)	(2)	(3)	(4)	(5)	(6)	(7)	(8)	hours each day

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31) On the job, I lift:

A) Occasionally*	1) 1-9,	2) 10-24,	3) 25-34,	4) 35-49,	5) 50-74,	6) 75-99,	7) 100 + pounds
B) Intermittent*	1) 1-9,	2) 10-24,	3) 25-34,	4) 35-49,	5) 50-74,	6) 75-99,	7) 100 + pounds
C) Frequently*	1) 1-9,	2) 10-24,	3) 25-34,	4) 35-49,	5) 50-74,	6) 75-99,	7) 100 + pounds
D) Constantly*	1) 1-9,	2) 10-24,	3) 25-34,	4) 35-49,	5) 50-74,	6) 75-99,	7) 100 + pounds

* (Occasionally= 25% of time **Intermittently**= 50% **Frequently**= 75% **Constantly**= 100%)

Patient's signature: _____ **Date:**_____/_____/_____

Authorization to Use or Disclose Protected Health Information

Cheeley Chiropractic, Inc.
900 East Washington St., Ste 300
Colton, CA 92324
Phone: (909) 533-4591 Fax: (909) 533-4597

Patient Name:_____

Address:_____

Date of Birth:_____ **Date Requested:**_____

As required by the Privacy Regulations, Cheeley Chiropractic, Inc. may not use or disclose your protected health information except as provided in or Notice of Privacy Practices without your authorization.

I hereby authorize Cheeley Chiropractic, Inc. and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), and/or business associates of this office:

_____

Patient Health Information authorized to be disclosed:

_____

For specific purpose of (describe in detail):

_____

Effective dates for this authorization: _____ through_____
This authorization will expire at the end of the above period.

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond the control of Cheeley Chiropractic, Inc.

I understand I have the right to:

1. Revoke this authorization by sending written notice to Cheeley Chiropractic, Inc. and previous reliance on the used or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under Federal Law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not affect my condition, my treatment, payment, enrollment in a health plan, or eligibility for benefits, whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature of Patient or Patient's Authorized Representative **Date**

_____ _____
Authorized Signature of Facility **Date**

Assignment and Instruction for Direct Payment to Doctor
Private and Group Accident and Health Insurance

Patient Name:_____

Name of Employer:_____

Claim/Group #:_____

SS#/ID#:_____

I hereby instruct and direct the _____ insurance Company

to issue check made out and mailed directly to:

Cheeley Chiropractic, Inc.

900 East Washington St., Ste 300
Colton, CA 92324

If my current policy prohibits direct payment to doctor, I hereby instruct and direct you to make out the check to me and mail it as follows:

C/O Cheeley Chiropractic, Inc.

900 East Washington St., Ste 300
Colton, CA 92324

The professional or medical expense benefits allowable and otherwise payable to me under my current insurance policy as payment toward the total charges for professional services. THIS IS A DIRECT ASSIGNMENT OF MY RIGHTS AND BENEFITS UNDER THIS POLICY. This payment will not exceed my indebtedness to the above-mentioned assignee, and I have agreed to pay, in a current manner and any balance of said professional service charges over and above the insurance payment.

A photocopy of this assignment shall be considered as effective and valid as the original.

I also authorize the release of any information pertinent to my case to any insurance company, adjuster or attorney involved in this case.

Dated at _____ this _____ day of _____ 20 _____

_____ _____

Signature of Patient or Patient's Authorized Representative **Date**

_____ _____

Authorized Signature of Facility **Date**

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 to the **self-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 this 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**	**PLEASE DO NOT USE THIS COLUMN**
2. **EMPLOYER NAME**	Case No.
3. Address No. and Street City Zip	Industry
4. Nature of business (e.g. food manufacturing, building construction, retailer of women's clothes)	County
5. **PATIENT NAME** (first name, middle initial, last name) 6. Sex ☐ Male ☐ Female 7. Date of Birth Mo. Day Yr.	Age
8. Address No. and Street City Zip 9. Telephone Number	Hazard
10. Occupation (Specific job title) 11. Social Security Number	Disease
12. Injured at: No. and Street City County	Hospitalization
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.	Occupation
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	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 effect 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.)