WORKERS' COMPENSATION INTRODUCTION FORM

Hokokian Chiropractic

1543 W. Shaw Ave, Fresno, Ca 93711

Office: (559) 230-1102 Fax: (559) 230-1105

Today's Date: _____

Last Name:	**MI:**	**First Name:**	
Home Address:	**City:**	**State:**	**Zip:**
Date Birth: Age:	Social Security No:		
Tel Home:	Tel. Work:		
Height: Weight:	Drivers License No:		
Employer's Name:	Marital Status (Circle): Single, Married, Divorced, Widowed		
Email Address:			

Name and Telephone Number of your nearest adult relative (for emergencies) _____

Date of Injury:	Date: Time:
Name Employer at Time of Injury:	
Address of Employer:	
Job Title at Time of Injury:	Title: Length of time employed (months/yrs): ____
Name of Current Employer:	

DESCRIBE HOW INJURY HAPPENED:

☐ YES, ☐ NO Have you notified your employer about your injury?
☐ YES, ☐ NO Has your employer notified their workers' compensation insurance carrier?
☐ YES, ☐ NO Have you filled out an injured workers' claim form?
☐ YES, ☐ NO Do you have an attorney representing you for this work-related injury?
If yes, provide name/address/telephone: _____
☐ YES, ☐ NO Have you missed any time off work?
If yes, please indicate the dates you have been off work: From: _____ To: _____ Other:

WORKERS' COMPENSATION INSURANCE INFORMATION

Name of Insurance Carrier:	
Address of Insurance Carrier:	
Claim Adjuster's Name/Telephone:	Name: Telephone:
Claim Number:	

The 1996 Health Insurance Portability and Accountability Act (HIPAA) require that all health care providers comply with patient privacy and security laws (45 CFR 164). Patient confidentiality and privacy/security applies to any **protected health information (PHI).** This notice explains how my protected health information (PHI) may be used and what their office's responsibilities are regarding my privacy rights and protected health information. Indicate whether you are the parent or a legal guardian of the patient or minor. If you want to discuss anything privately that you do not want to be overheard by other patients or persons in the doctor's office, please inform the staff before you see the doctor so a private room can be arranged. Please sign and date below.

Patient Signature and Date	By signing this form, I acknowledge that this office has presented me with a copy of their HIPAA privacy practices and I have been able to read the practice policies notice that is posted on the waiting room wall.

Patient Name: _____ Date: _____

GENERAL HEALTH HISTORY
Hokokian Chiropractic
1543 W. Shaw Ave, Fresno, Ca 93711
Office: (559) 230-1102 Fax: (559) 230-1105

Check only those conditions that apply to you and indicate if you have had in the past or presently have.

YES	GENERAL QUESTIONS	PAST	PRESENT
☐	I heal slowly	☐	☐
☐	Smoke cigarettes or use tobacco products	☐	☐
☐	Diabetes, hypoglycemia, thyroid disorder, kidney or liver disease, or tuberculosis	☐	☐
☐	Heart attack or have a heart pacemaker or neck or chest shunt?	☐	☐
☐	Currently or recently had any infectious disease such as AIDS, Tuberculosis, etc	☐	☐
☐	Do you have difficulties or intolerance to heat packs or ice packs on your skin?	☐	☐
☐	Do you have problems with dizziness, blacking out, balance, fainting, or tripping	☐	☐
☐	Epilepsy-Seizure-Convulsion history or other neurological disease	☐	☐
☐	History of multiple sclerosis, lupus, psoriasis, temporary paralysis, or meningitis	☐	☐
☐	Cancer history or cancer treatment of any type	☐	☐
☐	Stroke history (Indicate any suspected strokes or transient ischemic attacks)	☐	☐
☐	Told that you have scoliosis, spondylolisthesis, spina bifida, or fused vertebrae	☐	☐
☐	Told that you have a bulging/herniated disc or disc degeneration in the spine	☐	☐
☐	Have you ever been hospitalized? Why:	☐	☐
☐	Blood clots, bleeding or vascular disorder, or told you have an abdominal aneurysm	☐	☐
☐	Hypertension or high blood pressure	☐	☐
☐	Told you have weak bones, osteoporosis, osteopenia, or ankylosing spondylitis	☐	☐
☐	Told you have osteoarthritis, rheumatoid arthritis, or gout of your spine or joints	☐	☐
☐	**Do you have any type of chest or breast implants presently (males & females)?**	N/A	☐
☐	**Women only**: Check box to left if there any chance that you are currently pregnant		

PRIOR INJURY OR PREVIOUS MUSCULOSKELETAL PAIN

(☐ I have no history of previous painful injury or pain) If you have had prior injuries or pain, please check below:

☐ Work Injury	☐ Fall	☐ Sports Injury	☐ Lifting Injury	☐ Car Accident
☐ Motorcycle Injury	☐ Head Injury	☐ Pedestrian Injury	☐ Military Injury	☐ Other Injury
☐ Headaches/Migraines	☐ Neck Pain	☐ Middle Back Pain	☐ Low Back Pain	☐ Shoulder Pain
☐ Arm numb-tingling	☐ Arm Pain	☐ Leg pain-numb-tingling	☐ Other Pain:	

HAVE YOU HAD FRACTURES/BROKEN BONES IN THE PAST?

☐ **NO. (Check box if you have never had any broken bones in the past).** If yes, please describe below:

HAVE YOU HAD ANY PREVIOUS SURGERIES?

☐ **NO. (Check box if you never had any surgical procedure).** If yes (including silicone implants, cancer, spine, herniated discs, genetic conditions, ports in the chest/abdomen), please describe type and when:

Have you ever been to a Chiropractor before for any condition?

☐ No, ☐ Yes If yes, Chiropractor's Name: _____ Year:_____
Problem(s) seen by Chiropractor for:

Patient Name: _____ Date: _____

GENERAL HEALTH HISTORY (Page 2)

Hokokian Chiropractic

1543 W. Shaw Ave, Fresno, Ca 93711

Office: (559) 230-1102 Fax: (559) 230-1105

LIST ALL SYMPTOM REGIONS AND HOW LONG YOU HAVE HAD THEM

CHECK ALL SYMPTOM AREAS	HOW LONG	CHECK ALL SYMPTOM AREAS	HOW LONG
☐ Headaches/Migraines		☐ Upper Back Pain, Soreness, or Stiffness	
☐ Neck Pain, Soreness, or Stiffness		☐ Hip Pain	
☐ Low Back Pain, Soreness, Stiffness		☐ Leg or Foot Pain, Numbness, or Tingling	
☐ Arm/Hand Pain, Numbness, or Tingling		☐ Other:	

Did your current symptoms come on? ☐ Suddenly, ☐ Gradually

SYMPTOM/PAIN DESCRIPTION

Please circle any word or all words below that best describes how your symptoms currently feel to you.

Pain	Pinching	Spreading	Vicious	Unbearable
Ache	Pricking	Shooting	Sickening	Soreness
Cutting	Tingling	Stabbing	Miserable	Pins and Needles
Tearing	Gnawing	Dull	Troublesome	Radiating
Crushing	Nagging	Bony	Pressing	Weakness
Pulling	Boring	Terrifying	Deep pain	Falls asleep
Irritating	Burning-Hot	Dreadful	Superficial pain	Suffocating
Annoying	Drill like	Fearful	Stinging	Punishing
Stiff or tight	Heavy	Unhappy	Throbbing	Crawling
Exhausting	Numbness	Torturing	Sharp	Tender

☐ No, ☐ Yes Do you have any problems laying face down on an examination table? If yes, why: _____

ARE YOU TAKING ANY MEDICATIONS?

☐ **I am not taking any medications currently.** Check any of the following that you are taking currently.

☐ Muscle Relaxants	☐ Blood pressure/Stroke prevention medications	☐ Cortisone injections
☐ Pain/Anti-inflammatory meds	☐ Osteoporosis (bone strengthening) medications	☐ Other:

WHEN IS YOUR PAIN WORSE & WHAT ACTIVITIES INCREASE YOUR PAIN?

☐ Morning is when pain is worse	☐ Bending your back increases pain	☐ Walking increases pain
☐ Afternoon/evening pain worse	☐ Lying down flat increases pain	☐ Standing increases pain
☐ During sleep hours pain worse	☐ Sitting increases pain	☐ Exercise/Stretching increases pain
☐ Standing up from sitting	☐ Poor posture increases pain	☐ Other:

WHAT ACTIVITIES LESSEN YOUR PAIN?

☐ Walking	☐ Being flat on your back	☐ Exercise/Stretching
☐ Sitting	☐ Standing	☐ Other:

DO YOU EXERCISE?

☐ I do no regular exercise	☐ I exercise 1-2 times a week	☐ I exercise 3-5 times a week
☐ I stretch regularly	☐ I do weight lifting at gym/home	☐ I do cardiovascular work outs
☐ I am willing to do exercise	☐ I am not willing to do exercises	☐ I do regular sports activities

HAS YOUR PAIN BEEN ASSOCIATED WITH ANY OF THE FOLLOWING?

☐ Excessive fatigue-malaise	☐ Bowel or bladder disorders	☐ Night pain or night time sweats
☐ Weight loss	☐ Ovarian pain	☐ Abdominal pain
☐ Low grade fever	☐ Kidney pain/painful urination	☐ Balance problems

Patient Name: _____ Date: _____

EMPLOYMENT INFORMATION

Hokokian Chiropractic
1543 W. Shaw Ave, Fresno, Ca 93711
Office: (559) 230-1102 Fax: (559) 230-1105

PATIENT NAME: _____ DATE: _____

CURRENT EMPLOYMENT STATUS (Check your present status)

☐	Full time employee	☐	Self employed
☐	Part time employee	☐	Unemployed

EMPLOYMENT HISTORY

EMPLOYER AT THE TIME OF THE INCIDENT FOR WHICH YOU ARE BEING SEEN

What is the name of your employer at the time of the injury? _____
Job title: _____ Number of hours working each week: _____
How many months or years had you been employed at the time of the injury? _____
What type of activities did you do at this job? (Describe details such as lifting, sitting, stooping, bending, and computer work)_____
_____

CURRENT EMPLOYER

☐ Yes, ☐ No Are you currently working for the same employer as when you had this injury? If no, indicate:
Name of current employer (if different than above): _____
Job Title: _____ Number of hours working per week: _____

SELF EMPLOYED INFORMATION

If you are self-employed or own a business, please describe your job duties.
_____
_____

PREVIOUS EMPLOYMENT (PAST 10 YEARS)

List in descending order, your three past employers or work positions from your last job backwards.

EMPLOYER NAME	DATES EMPLOYED	JOB TITLE/DUTIES
A.		
B.		
C.		
D.		
E.		
F.		

Patient Name: _____ Date: _____

JOB DESCRIPTION (DUTIES) AT TIME OF INJURY

Hokokian Chiropractic

1543 W. Shaw Ave, Fresno, Ca 93711

Office: (559) 230-1102 Fax: (559) 230-1105

PATIENT NAME: _____ DATE: _____

What was your job title/description?	
How many hours did you work in a typical day?	
How many hours did you work in a typical week?	

JOB DUTIES AT TIME OF INJURY ***(Check column that applies to the frequency of a specific activity at your job)***	**Never** (0 hours)	**Occasionally** (1-15 x/hr) (Up to 3 hours)	**Frequently** (16-60 x/hr) (3-6 hours a day)	**Constant** (More than 60 x/hr) (6-8 hours a day)
Bending head and neck				
Twisting head and neck				
Bending waist				
Twisting waist				
Lifting less than 25 pounds				
Lifting heavier than 25 pounds				
Bending while lifting				
Reaching above the level of your head				
Reaching above the level of your shoulder				
Carrying objects in hand				
Gripping or fingering objects left hand				
Gripping or fingering objects right hand				
Fine movement with fingers				
Handwriting				
Pushing and pulling with left hand				
Pushing and pulling with right hand				
Keyboarding on computer				
Heavy or power use of hands				
Crawling				
Crouching or squatting				
Walking				
Kneeling				
Standing				
Climbing				
Sitting while driving a vehicle				
Sitting (other than driving)				

YES	**NO**	**CHECK ALL THAT APPLIES TO YOUR EMPLOYEMENT AFTER YOUR INJURY**
☐	☐	Has your employer modified your work environment/job tasks to make it easier for you to work?
☐	☐	Did you have to ask other employees to help you perform job related tasks after the injury?
☐	☐	Did you make changes in how you worked on the job to allow yourself to keep working?

Patient Name: _____ Date: _____

PRIMARY TREATING PHYSICIAN'S PROGRESS REPORT

Hokokian Chiropractic

1543 W. Shaw Ave, Fresno, Ca 93711

Office: (559) 230-1102 Fax: (559) 230-1105

(Workers' Compensation)

PATIENT NAME:		REPORT **DATE:**	
Address:		SSN:	
Occupation:		Date of Birth:	
Telephone:		Gender:	

Claims Administrator:		Injury Date:	
Address:		Claim No:	
Telephone:		**Employer** Name:	
Fax No:		Telephone:	

I. REASON FOR SUPPLEMENTAL REPORT

☐	Periodic treatment status report.
☐	Periodic status report, patient being treated under future medical award.
☐	Change in employee's work status.
☐	There is a change in the patient's condition or a test finding that requires a significant change in the treatment plan.

II. PATIENT STATUS-RESPONSE TO TREATMENT

A. Since the last report/exam this patient's condition has:

☐	Improved normally as expected.	☐	Worsened significantly.
☐	Improved, but more slowly than expected.	☐	Begun to plateau and stabilize.
☐	Not improved significantly.	☐	Been discharged or is being discharged from care.

☐ Yes	☐ No	Is a Consultation necessary at this time?	☐ Yes	☐ No	Is a Referral necessary at this time?
☐ Yes	☐ No	Has patient been complying with treatment?	☐ Yes	☐ No	Are there any mitigating/aggravating factors?

B. Discussion about changes in patients condition, new injuries, aggravating factors or treatment plan:

C. Current Diagnosis :

III. CURRENT SUBJECTIVE FINDINGS (Use Patient's words to describe complaints).

	LOCATION-DESCRIPTIVES	INTENSITY	FREQUENCY	RESOLVED
☐	Headache/Migraine	None/Min/Slight/Moderate/Severe	None/Occ/Inter/Freq/Constant	
☐	Neck Pain/Soreness/Stiffness	None/Min/Slight/Moderate/Severe	None/Occ/Inter/Freq/Constant	
☐	Mid Back Pain/Soreness/Stiffness	None/Min/Slight/Moderate/Severe	None/Occ/Inter/Freq/Constant	
☐	Low Back Pain/Soreness/Stiffness	None/Min/Slight/Moderate/Severe	None/Occ/Inter/Freq/Constant	
☐		None/Min/Slight/Moderate/Severe	None/Occ/Inter/Freq/Constant	
☐		None/Min/Slight/Moderate/Severe	None/Occ/Inter/Freq/Constant	

Min = minimum (annoyance), Occ = occasional 25%, Inter = Intermittent 50%, Freq = frequent 75%, Constant = 90-100%, SI = Sacroiliac,

Patient Name: _____ Date: _____

Page Two-Primary Treating Physician's Progress Report (Work Comp) Hokokian Chiropractic

1543 W. Shaw Ave, Fresno, Ca 93711
Office: (559) 230-1102 Fax: (559) 230-1105

Patient Name:

V. CURRENT TREATMENT PLAN & MANAGEMENT OBJECTIVES

☐ Spinal/Sacroiliac/Extremity Adjustments	☐ Flexion-Distraction	☐ Improve Joint Range-of-Motion
☐ Myotherapy/Trigger Point Therapy	☐ Electrical Stimulation/Ultrasound	☐ Improve Soft Tissue Motion
☐ Posture/Ergonomic Modification (Home/Work)	☐ Ice/Heat packs (Office/Home)	☐ Reduce Pain/Paresthesias
☐ Intersegmental Traction	☐ Lumbar Bracing	☐ Stabilize Condition
☐ Cervical Traction	☐ Wrist Splint	☐ Improve Functional Capacity
☐ Exercises/Stretching (Office/Home/Gym)	☐ Orthotics	☐ Enhance Repair/Remodeling
☐	☐	☐

VI. PLANNED COURSE OF TREATMENT (Estimate)

Estimated date or time for treatment conclusion: ☐ _____ weeks, ☐ _____ months, ☐ _____ ☐ Treatment under future medical award. Patient schedules appointments when pain reaches moderate-to-severe level.	Notes about any diagnostic tests, surgeries, hospitalizations, consultations, or other findings:
Treatment will continue at the indicated frequency at right. Treatment frequency will lessen as this patient's condition improves.	☐ Daily for 1-2 wks, ☐ 3x wk for ___ wks, ☐ 2x wk for ___ wks, ☐ 1x week for ___ weeks, ☐ ___x every ___ wks/mo for _____, ☐ Seen on an as needed basis only (PRN).

VII. PRESENT WORK STATUS

☐	Returned to full work duty with no limitations and/or modifications on date:
☐	Employee remains off work with (temporary/permanent) limitations/modifications (see attached).
☐	Employee is on total (temporary/permanent) (partial/total) disability. Disability dates from: to:
☐	Return to modified work (see attached) on date:
☐	Other:

VIII. PERMANENT DISABILITY/IMPAIRMENT STATUS

☐	(I anticipate/ I do not anticipate/ I am unable to anticipate) permanent disability/impairment at this time.
☐	Patient's condition is stabilizing and should be at pre-injury status by (Date):
☐	Patient has not yet reached MMI/P&S status. (Unable to predict when/Will be able to better predict) on:
☐	Patient has been discharged from treatment having reached MMI as of the date of this report with nonratable subjective/objective factors of disability/impairment. He/She has reached pre-injury level or residuals are nonratable.
☐	Patient has been discharged from curative treatment having reached maximum medical improvement status as of the date of this report with permanent ratable subjective/objective factors of impairment/disability. A final report will follow.
☐	Patient has been discharged from curative treatment having reached P&S status with ratable subjective/objective factors on (date:). Future medical award is pending and treatment is supportive in nature as needed.
☐	Patient is being treated under future medical award and has been previously rated with a permanent disability/impairment.

"I declare under penalty of perjury that this report is true and correct to the best of my knowledge and I have not violated any labor codes."

_____
(Physician's Signature)

Patient Name: _____ Date: _____

SECONDARY TREATING PHYSICIAN'S PROGRESS REPORT

Hokokian Chiropractic

1543 W. Shaw Ave, Fresno, Ca 93711

Office: (559) 230-1102 Fax: (559) 230-1105

(Workers' Compensation)

PATIENT NAME:		REPORT **DATE:**	
Address:		SSN:	
Occupation:		Date of Birth:	
Telephone:		Gender:	

Claims Administrator:		Injury Date:	
Address:		Claim No:	
Telephone:		**Employer** Name:	
Fax No:		Telephone:	

Name of Primary Treating Physician:	

I. REASON FOR PROGRESS REPORT

☐	Periodic status report	☐	Authorization for additional & continued treatment
☐	Change in patient's condition	☐	Authorization for testing
☐	Change in patient's work status	☐	Other

II. CURRENT SUBJECTIVE COMPLAINTS (Use Patient's words to describe complaints).

	LOCATION-DESCRIPTIVES	INTENSITY	FREQUENCY	RESOLVED
☐	Headache/Migraine	None/Min/Slight/Moderate/Severe	None/Occ/Inter/Freq/Constant	
☐	Neck Pain/Soreness/Stiffness	None/Min/Slight/Moderate/Severe	None/Occ/Inter/Freq/Constant	
☐	Mid Back Pain/Soreness/Stiffness	None/Min/Slight/Moderate/Severe	None/Occ/Inter/Freq/Constant	
☐	Low Back Pain/Soreness/Stiffness	None/Min/Slight/Moderate/Severe	None/Occ/Inter/Freq/Constant	
☐	Arm/Hand/Leg numbness/tingling	None/Min/Slight/Moderate/Severe	None/Occ/Inter/Freq/Constant	
☐		None/Min/Slight/Moderate/Severe	None/Occ/Inter/Freq/Constant	

Min = minimum (annoyance), Occ = occasional 25%, Inter = Intermittent 50%, Freq = frequent 75%, Constant = 90-100%, SI = Sacroiliac,

III. OBJECTIVE OR CLINICAL FINDINGS (Physical Exam, Imaging, Diagnostic)

IV. ICD-9 CODE — CURRENT DIAGNOSIS

1.		
2.		
3.		

V. TREATMENT PLAN (METHODS) & MANAGEMENT OBJECTIVES

☐ Spinal/Sacroiliac/Extremity Adjustments	☐ Flexion-Distraction	**TREATMENT OBJECTIVES**
☐ Myotherapy/Trigger Point Therapy	☐ Electrical Stimulation	☐ Improve Joint Range-of-Motion
☐ Posture/Ergonomic Modification (Home/Work)	☐ Ultrasound	☐ Improve Soft Tissue Motion
☐ Intersegmental Traction	☐ Ice/Heat packs (Office/Home)	☐ Reduce Pain/Paresthesias
☐ Cervical Traction	☐ Lumbar Bracing	☐ Strengthen Involved Areas
☐ Exercises to Strengthen Neck/Middle/Low Back	☐ Wrist Splint	☐ Stabilize Condition
☐ Exercises to Strengthen the Extremities	☐ Orthotics	☐ Improve Functional Capacity
☐ Stretching Daily at Home or Gym	☐ Other	☐ Enhance Repair/Remodeling
☐		☐ Lessen Risk for Chronicity

Patient Name: _____ Date: _____

Secondary Treating Physician's Progress Report

Hokokian Chiropractic

1543 W. Shaw Ave, Fresno, Ca 93711

Office: (559) 230-1102 Fax: (559) 230-1105

Patient Name:

TREATMENT PLAN-DURATION AND FREQUENCY (Estimate)

Estimated date or time for treatment conclusion: ☐ _____ weeks, ☐ _____ ☐ Yes, ☐ No Patient has complied with treatment plan.	Notes about any diagnostic tests, surgeries, hospitalizations, consultations, or other findings:
Treatment will continue at the indicated frequency noted in column to the right. Treatment frequency will lessen as this patient's condition improves.	☐ Daily for 1-2 wks, ☐ 3x wk for ___ wks, ☐ 2x wk for ___ wks, ☐ 1x week for ___ weeks, ☐ ___x every ___ wks/mo for _____

REQUEST FOR AUTHORIZATION FOR ADDITIONAL TREATMENT

☐ **No,** ☐ **Yes** Request authorization for additional treatment?
If yes, How many additional office visits being requested? _____
Notes about request for additional visits being authorized by primary treating physician:

VI. PRESENT WORK STATUS

☐	Returned to full work duty with no limitations and/or modifications on date:
☐	Employee remains off work with (temporary/permanent) limitations/modifications (see attached).
☐	Employee is on total (temporary/permanent) (partial/total) disability. Disability dates from: to:
☐	Return to modified work (see attached) on date:

VII. PATIENT STATUS-RESPONSE TO TREATMENT

A. Since the last report/exam this patient's condition has:

☐	Improved normally as expected.	☐	Improved, but more slowly than expected.	☐	Other

B. Changes in treatment plan due to flare-ups, new injuries, or aggravating factors. (Explain why)

VIII. DISCHARGE STATUS, P&S AND PERMANENT DISABILITY STATUS

☐	(I anticipate/ I do not anticipate/ I am unable to anticipate) permanent disability at this time.
☐	Patient's condition is stabilizing and should be at pre-injury status and discharged on (Date):
☐	Patient is not Permanent & Stationary currently. (Unable to predict when/Will be able to better predict) on:
☐	Patient has been discharged from treatment having reached maximum medical improvement as of the date of this report with nonratable subjective/objective factors of disability. He/She has reached pre-injury level or residuals are nonratable.
☐	Patient has been discharged from curative treatment having reached Permanent & Stationary status as of the date of this report. There are permanent ratable subjective/objective factors of disability/occupational preclusions. The primary treating physician will provide a report for you.
☐	Other

"I declare under penalty of perjury that this report is true and correct to the best of my knowledge and I have not violated any labor codes."

_____ Date of exam: _____ Next report date: _____

(Secondary Treating Physician's Signature)

Patient Name: _____ Date: _____

EMPLOYEE'S PREDESIGNATION OF PERSONAL CHIROPRACTOR OR MEDICAL DOCTOR

Hokokian Chiropractic
1543 W. Shaw Ave, Fresno, Ca 93711
Office: (559) 230-1102 Fax: (559) 230-1105

Note: DC's in California can only be predesignated if employer or carrier hasn't established an MPN. 8CCR Sect 9281-9282

TO: PERSONNEL OFFICE

Date Predesignating Personal Physician: _____

Name of Employee:	
Name of Employer:	

PREDESIGNATION OF PERSONAL CHIROPRACTOR

This letter serves as a formal notification to my employer that if, during the course of my employment I experience a single event or a cumulative industrial injury, including any musculoskeletal injury (excluding fractures), strains, sprains, neck pain, back pain, headaches, arm or leg symptoms, and wrist or feet problems that I be treated by my predesignated personal Chiropractor. I hereby designate (name) _____, my licensed regular physician, as my **"Predesignated Personal Chiropractor"** pursuant to Section _____ of the _____ Labor Code. Dr. (name) _____, located at (Address) _____ is my Chiropractor who has previously directed my treatment and who retains my medical history and medical records.

PREDESIGNATION OF PERSONAL MEDICAL DOCTOR

This letter serves as a formal notification to my employer that if, during the course of my employment I experience an industrial injury other than those treated by my predesignated personal Chiropractor, including any fractures, lacerations, burns, head injuries, industrial illness, and/or other nonmusculoskeletal problems that I be treated by my predesignated personal Medical Doctor.

I hereby designate (Name Doctor) _____, MD, as my **"Predesignated Personal Medical Doctor"** pursuant to Section _____ of the (State) _____ Labor Code. Doctor. (name) _____, located at (Address) _____is my Medical Doctor who has previously directed my treatment and who retains my medical history and medical records.

_____ _____

(Signature of Employee) (Printed Name of Employee)

This form is to be signed by personnel office member and a photocopy made and given to the employee.

Signature of Personnel Office: _____ Date: _____

Patient Name: _____ Date: _____

INFORMED CONSENT
Hokokian Chiropractic
1543 W. Shaw Ave, Fresno, Ca 93711
Office: (559) 230-1102 Fax: (559) 230-1105

I hereby consent to the performance of chiropractic adjustments and other chiropractic procedures, on myself, (or on the patient names below, for whom I am legally responsible) by **Dr. John H. Hokokian, D.C.,** and/or other licensed doctors of the chiropractic who now or in the future provide chiropractic adjustments and other types of treatment for me. This consent includes other doctors of chiropractic that are employed by, associated with, or serve as back-up for **Dr. John H. Hokokian, D.C.,** whether or not their names are listed on this form.

I understand and consent to the following procedures (checked below):

☐ Examination ☐ Mobilization ☐ Ultrasound ☐ Muscle Stimulation
☐ X-rays ☐ Traction ☐ Adjustments

I have had an opportunity to discuss with **Dr. John H. Hokokian, D.C.,** the various types of treatment, including neck and spinal/extremity adjustments that have been proposed to me for my condition, and the purpose and objectives of these chiropractic procedures. I understand that the results from the chiropractic treatment are not guaranteed for my condition.

I have been informed about the risks and benefits of chiropractic adjustments and other chiropractic procedures, and understand that, there are some uncommon potential serious risks to chiropractic adjustments and procedures, including, but not limited to, sprains, fractures, disc injuries, dislocations, nerve injuries, and strokes specifically from neck adjustments. I understand and have had the opportunity ask about risks and benefits the proposed treatment and of other alternative types of treatment for my condition.

I have had the opportunity to read this form understand the above statements, accept the risks mentioned, and hereby consent and agree to chiropractic treatment over the entire course of treatment for my present condition and any future conditions for which I seek treatment.

PATIENT NAME (PRINT) _____DATE:_____

X_____
SIGNATURE OF PATIENT OR RESPONSIBLE PARTY

(If signing for a MINOR)
NAME: _____RELATIONSHIP:_____

OFFICE/WITNESS SIGNATURE: _____ DATE: _____

Proof of Service

I am at least 18 years of age, not a party to this action, and I am a resident of or employed in the county where the mailing took place.
My business address is: **1543 W. Shaw Ave Fresno CA 93711**
On _____, I served a true copy of the following documents, along with supporting documents described as: LIEN FORM AND ITEMIZED STATEMENT
By enclosing them in a sealed envelope addressed to each of the parties named and at the address set forth in the Party List, and placing each envelope for collection and mailing at the business address herein following our ordinary business practices, with postage fully prepaid, or by other previously agreed-upon method of electronic service.
I declare under penalty of perjury under the laws of the State of California that the foregoing is true and correct.
Dated: _____
Declarant Signature_____

Party List

_____
_____
_____
_____