DOCTOR'S FIR[illegible]REPORT OF OCCUPATIONAL IN[illegible]RY 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** KEENAN & ASSOC. 392 D. CONNORS COURT CHICO CA 95926

PLEASE DO NOT USE THIS COLUMN

Case No.

2. **EMPLOYER NAME** San Joaquin County Mosquito abatement District

3. Address: No. and Street S. Airport City Stockton Zip

Industry

4. Nature of business (e.g., food manufacturing, building construction, retailer of women's clothes) County abatement - mosq control

County

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

6. Sex ☒ Male ☐ Female

7. Date of Birth Mo. Day Yr.

Age 39

8. Address: No. and Street City Zip

9. Telephone Number

Hazard

10. Occupation (Specific job title) Mosq Control Tech II - Asst Sup.

11. Social Security Number

Disease

12. Injured at: No. and Street Escalon City Escalon County St Co.

Hospitalization

13. Date and hour of injury or onset of illness Mo. 1 Day 27 Yr. 92 Hour a.m. p.m.

14. Date last worked Mo. Day Yr. 1/31/92

Occupation

15. Date and hour of first examination or treatment Mo. 2 Day 2 Yr. 92 Hour a.m. 1.30 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 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.) Back-pack spraying herbicides - that evening I noticed soreness of clavical - some swelling neck pain. numbness in left hand.

18. **SUBJECTIVE COMPLAINTS** (Describe fully. Use reverse side if more space is required.)
1)BILATERAL NECK SHOULDER PAIN, PAIN ON CERVICAL ROTATION
2) LEFT HAND-ARM NUMBNESS-TINGLE SENSATION

19. **OBJECTIVE FINDINGS** (Use reverse side if more space is required.)
A. Physical examination PALPABLE LOWER CERVICAL, UPPER THORACIC MUSCLE SPASMING & TENDERNESS, RT. UPPER THORACIC EDEMA. RESTRICTED CERVICAL RANGE OF MOTION WITH PAIN ON FLEXION AND EXTENSION ON THE LOWER CERVICAL REGION. POSITIVE ALLENS TEST
B. X-ray and laboratory results (State if none or pending.) ON THE LEFT AND POSITIVE ADSONS TEST OVER--

20. **DIAGNOSIS** (If occupational illness, specify etiologic agent and duration of exposure.) Chemical or toxic compounds involved? ☐ Yes ☐ No
CERVIOCOBRACHIAL SYNDROME 723.3
CERVICALGIA 723.1 HEADACHE 784.0

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.)
CHIROPRACTIC SPINAL MANIPULATIVE THERAPY WITH PHYSIO THERAPY OF ULTASOUND ELECTRIC STIMULATION OR HOT MOIST HEAT
If further treatment required, specify treatment. YES Estimated duration 6-8 WEEKS

24. If hospitalized as inpatient, give hospital name and location. NO Date admitted Mo. Day Yr. Estimated stay

25. **WORK STATUS** Is patient able to perform usual work? ☐ Yes ☒ No
If "no", patient can return to: Mo. Day Yr.
Regular work 2-13-92
Modified work 2-7-92
Specify restrictions NO HEAVY LIFTING OVER 25 LBS. ARM LIFTING/SPRAYING. NO BACKPACK SPRAYING

Doctor's Signature [signature] Date 2-10-92
CA License Number dc-16807
Doctor Name and Degree (Please Type) DOUGLAS A. PFEIFLE D.C.
IRS Number 68-0190088
Address 18962 N. HWY 88 LOCKEFORD CA 95237
Telephone Number (209) 727-5557

Incomplete Information or delay in submitting this report may cause delay in benefits to your patient.

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