

Performance Health Medical Group, Inc.

27062 South La Paz ♦ Aliso Viejo, California 92656

Tel (949) 362-8877 ♦ Fax (949) 362-9230

Federal First Report of Injury

Patient Please Complete Numbers 1-13

1) Employer Name: United States Postal Service Supervisor Name: Phone #:

2) Address: City: Zip:

3) Job Description: (Specific time spent on each involvement which contributed to injury)

4) Patient Name:

5) Sex: Male Female 6) Date of Birth:

7) Address: City: Zip: 8) Phone #: ()

9) Social Security #: 10) Date and hour of injury or onset of illness: (first realized injury was caused by employment)

11) Date last worked: 12) Date and hour of first exam or treatment:

13) Patient please complete the portion: Describe how the accident or injury occurred (Give complete description of injury or illness)
Patient's written statement: "mmmm"

14) Subjective Complaints (describe fully: use reverse side if more space is required)

15) Objective Findings (use reverse side if more space is required)

Physical Exam:

16) Diagnosis: Traumatic Injury Occupational (Repetitive Strain) Psych
1.

17) Are your findings and Diagnosis consistent with patient's account of injury or onset of illness? Yes No If "No," please explain :

18) Is there any other current condition that will impede or delay patient's recovery? Yes No If "Yes," please explain:

19) Treatment required, specify treatment plan, diagnostic test, referral request and estimated duration.

1. m
2. m

20) Physician's opinion as to whether the injury or illness was caused or aggravated by the employment, along with an explanation of the basis for this opinion (use reverse side if required)

21) Work Status: Is patient able to perform usual work? Yes No Regular: / /
If "No," date patient expected to return to work:

Doctors Signature: Thomas Oliveira D.O. California License No.: C-35815 Specialty: Family and Industrial medicine Date: