



Click on any field to start editing.

Chiropractor Initial Report

WCB Claim No: _____

Worker's Name: _____

Clinic Name: _____ Clinic Number: _____ Provider Number: _____ Phone: _____ Fax: _____ Care Provider Name, Address, Postal Code Print/Stamp/Sticker	Provincial Health Number: _____ Date of Birth: _____ Phone: _____ Employer Name: _____ Worker Name, Address, Postal Code Print/Stamp/Sticker
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Recurrent Treatment? No Yes. If yes, approx. last treatment date _____ d/m/y (WCB Approval Required)

CLINICAL

1. Date of Injury: _____ d/m/y 2. Date of this Exam: _____ d/m/y

3. Part of Body Injured: _____

4. Diagnosis: _____

5. Mechanism of injury: _____

6. Subjective complaints: _____

7. Objective clinical findings: (including quantifiable measures such as ROM in degrees/percentage, manual muscle testing graded out of 5, SLR, DTR, sensation, limb girth) etc. _____

8. Functional Outcome Measure: Roland Morris _____ Quick Dash _____ QD Work module _____ NDI _____ LEFS _____

9. Assessment of recovery (0-10) status _____ (0 = no recovery, 10 = recovered to preinjury) 10. Intensity score 0 1

11. Are you aware of previous injury/treatment for this area No Yes. Date: _____

Explain _____

MANAGEMENT

12. Investigations ordered: if applicable x-ray CT MRI other: _____

13. Management Plan: Medication Chiropractor Physical Therapist Massage Specialist Surgery
 Secondary/Tertiary Treatment Other
 Provide Details _____

14. Treatment plan: Biomechanical Electro-physical Agent
 Regional Conditioning Supervised _____ Home
 Supervised global conditioning _____
 Education Transitional RTW Other _____

15. Frequency of treatment: _____ per week, Other _____
 Expected date of discharge from treatment _____ d/m/y

16. Have you contacted the employer regarding current restrictions?
 Yes. Date of Contact _____ d/m/y Name: _____
 No.





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RETURN TO WORK

17. Is the worker off work as a result of the work injury? Yes No

Who advised the worker to be off work? Chiropractor Physical Therapist Medical Doctor Worker has taken themselves off work.

If off of work how long do you anticipate the worker to be off work? _____ days Other.

Has a return to work been arranged? Yes No. If yes who arranged the RTW? Chiropractor
 Physical Therapist Medical Doctor Employer. Name: _____

If no, please explain: _____

18. Return to work date: _____ d/m/y

19. If worker is at work: Are they currently working with restrictions? No Yes
 How long are restrictions expected to remain? _____ days Unknown Other _____

20. Estimated current restrictions? Subjective Objective

lifting _____ pushing/pulling _____ reaching _____
 overhead reaching _____ turning _____ walking _____ stairs _____
 ladders _____ standing (hours) _____ sitting (hours) _____
 environment _____ other _____

Client and Practitioner agreed Yes No (explain in comments)

21. Would you like to complete the Electronic Return to Work Form(PRTW) Yes No (RTW form needs to be completed 1 week before RTW).

22. Comments RTW _____

23. General Comments: _____

Signature: _____ **Please sign form before mailing/faxing.** Date: _____

