Saskatchewan Workers' Compensation Board
200-1881 Scarth Street
Regina SK S4P 4L1
www.wcbsask.com
Tel: 306.787.4370
Toll free: 1.800.667.7590
Fax: 306.787.4311
Toll-free fax: 1.888.844.7773

Click on any field to start editing.

CHI

Reset Form

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

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 ☐ 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: Weekly ☐ 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. Provide Expected Date of Contact _____ d/m/y

MISSION: ZERO

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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 ☐ Unknown ☐ 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. Anticipated 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 _____ lbs ☐ pushing/pulling _____ lbs ☐ 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: _____

MISSION: ZERO