



Click on any field to start editing.

Chiropractor Progress 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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Request for Extension Denied CES/CM _____ Date _____ d/m/y

CLINICAL

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

2. Current Diagnosis: _____

3. Body Areas currently being treated: _____

4. Subjective complaints: _____

5. 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. _____

6. Self Report(Initial/Current): Roland Morris ___ / ___ Quick Dash ___ / ___ QD Work module ___ / ___ NDI ___ / ___ LEFS ___ / ___

7. Assessment of recovery status(0-10) _____ (0 = no recovery, 10 = recovered to preinjury)

8. Discharge from treatment No Yes. If Yes, Date of discharge: _____ d/m/y

Did the worker return to their regular duties? Yes No.

MANAGEMENT

9. Results of diagnostics since previous report if applicable: _____

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

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

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

13. Are you aware of other health or non-health factors affecting recovery: Yes No. Explain: _____

14. Would you like WCB to arrange/expedite diagnostic Specialist assessment team review Other.
 Details: _____

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





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RETURN TO WORK

16. 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: _____

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

18. If worker is at work: Are they currently working with restrictions? No Yes
 How long are restrictions expected to remain? _____ days Unknown Other _____
 Anticipated date of full hours/duties: _____ d/m/y

19. Estimated current restrictions? Subjective Objective
 lifting _____ pushing/pulling _____ reaching _____
 overhead reaching _____ turning _____ walking _____ stairs _____
 ladders _____ standing (hours) _____ sitting (hours) _____
 environment _____ No restrictions
 other _____

Client and Practitioner agreed Yes No (explain in comments)

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

21. Comments RTW _____

22. General Comments: _____

Signature: _____ Date: _____

Please sign form before mailing/faxing.

