Saskatchewan Workers' Compensation Board
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CHP

Click on any field to start editing.

Reset Form

Chiropractor's Progress Report

WCB Claim No: _____

Clinic No.: _____ Doctor No.: _____ Personal Health No.: _____

Phone No.: _____ Fax No.: _____ Date of Birth: _____ Phone No.: _____

Employer Name:

Physician's Name, Address, Postal Code

Worker's Name, Address, Postal Code

Clinic Name:

REQUEST FOR EXTENSION ☐ DENIED CES/CM Date:

1. Examination date: _____ 2. Current Diagnosis: _____
3. Body areas currently being treated: _____
4. Subjective Complaints: _____

5. Objective findings: _____

6. Results of diagnostics since previous report _____
7. Assessment of recovery (0-10) initial _____ current _____ 0 = none, 10 = preinjury
   Explain any delay in recovery: _____
8. Have you advised the patient to be off work due to the injury? ☐ yes ☐ no (if yes, complete #10 - 21)
   If no, is the patient to be working with restrictions? ☐ yes ☐ no (if yes, complete #10 - 21)
9. Discharged ☐ yes, date: _____ ☐ no, requires a Request for Extension of Treatment (complete #10 - 21)
10. Self report (Initial/current) Roland Morris ___/___ Quick Dash ___/___ QD Work module ___/___ NDI ___/___ LEFS ___/___
11. Treatment plan: ☐ physical therapist* ☐ massage* ☐ specialist* ☐ hospitalized* ☐ education
    ☐ biomechanical ☐ electrophysical ☐ regional conditioning, supervised _____ Home _____ ☐ transitional RTW
    ☐ supervised global conditioning *Please name (med., caregiver) _____
12. Frequency of treatment _____ per week 13. Expected number of weeks to discharge _____
14. Would you like WCB to arrange/expedite ☐ diagnostic ☐ specialist ☐ assessment type/name _____
15. Are you aware of other health or non-health factors affecting recovery ☐ no ☐ yes (if yes, add to comments)
16. Estimated restrictions include: ☐ lifting (~ # of lbs) _____ lbs ☐ pushing/pulling (~ # of lbs) _____ lbs ☐ reaching
    ☐ overhead reaching ☐ turning ☐ walking _____ ☐ stairs _____ ☐ ladders _____
    ☐ standing (~ # of hrs) _____ ☐ sitting (~ # of hrs) _____ ☐ environment: _____ ☐ other: _____
17. Effects of the injury may affect activity for: ____ # of days if <8 days ☐ 8-14 days ☐ 15-21 days ☐ > 21 days RTW date: _____
18. Has transitional RTW been discussed with the worker? ☐ yes ☐ no the employer? ☐ yes ☐ no
19. Has a transitional RTW been arranged? ☐ yes TRTW start date: _____ ☐ no (explain in comments)
20. Are there any specific safety or medication concerns in a TRTW? ☐ no ☐ yes (explain in comments)
21. Comments: _____

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