

CHI USER MANUAL

Chiropractor's Initial Report

WCB Claim No. _____

Clinic No. _____	Chiro No. _____	Personal Health No. _____	
Phone No. _____	Fax No. _____	Date of Birth _____	Phone No. _____
Chiropractor's Name, Address, Postal code		Employer Name _____	
		Worker Name, Address, Postal Code	
Print/stamp/sticker		Print/stamp/sticker	
Clinic Name _____			

(The employer to be included in above should be the pre-injury employer. It is understood that there may be some instances where the current employer is different from the pre-injury employer. It is requested that this section only include the pre-injury employer)

1. **Date of injury:** _____ d/m/y 2. **Date of initial Exam:** _____ d/m/y
3. **Part of Body Injured:** *(i.e. Shoulder, neck, leg)* 4. **Diagnosis:** *(Be specific i.e. Grade 2 LBP)*
5. **Mechanism of injury:** *(Where possible please be as specific as possible)*
6. **Subjective complaints:** *(Include quantifiable measures where possible i.e. Numeric pain scale rating)*
7. **Objective Findings:** *(Include quantifiable measures where possible i.e. Range of motion, straight leg raise testing, manual muscle testing, deep tendon reflex testing.)*
8. **Investigations ordered:** xray other *(If previous pertinent diagnostic reports are available attach to CHI or CHP)*
9. **Assessment of recovery status (0-10):** _____ 0 = none, 10 = preinjury *(The assessment of recovery is a measure that asks the provider to summarize available information to provide an estimate of the expectation of recovery within typical primary timelines. The clinician is asked to incorporate clinical findings, self-report measure change, objective functional change where testing is appropriate as well as possible psychosocial issues. A score between 0 and 10 representing no recovery and 10 representing recovery to pre-injury status is established. This score will represent the practitioners' assessment of the complexity of this worker on initial presentation and potential for recovery.)*
10. **Intensity Score:** 0 1 *(An Intensity score is the Chiropractor's clinical opinion based on the case history and physical examination whether given a normal primary treatment program the injured worker will make a successful recovery = 0. A high intensity or complex case which may require more multidisciplinary or comprehensive primary treatment for a successful recovery = 1).*
11. **Treatment Plan:** Physical Therapist* Massage* Specialist* Hospitalized* Education
Biomechanical Electrophysical Regional conditioning, Supervised ___ Home ___
Supervised global conditioning Transitional RTW *Please name(med., caregiver)____ *(This section is meant to communicate services that you have included in your treatment plan. Also, please identify if you are aware of other caregivers who are involved in the care of the worker even if you didn't refer to these practitioners.)*



12. Frequency of treatment: _____ per week 13. Expected number of weeks to discharge (This should represent the total expected number of weeks to discharge)

14. Have you advised the patient to be off work due to the injury Yes No (if yes, complete #15 – 22)

If NO, is the patient to be working with restrictions? Yes No (if yes, complete #15 – 22)

15. Are you aware of previous injury/treatment for this area No Yes Date(s): (This is dependant on the worker's recall of previous injuries. Therefore, the year of injury is satisfactory. Please include details of his/her previous injuries in the comments section including time loss, type and length of treatment.)

16. Self-Report (score) Roland Morris _____ Quick Dash _____ QD Work module _____ NDI _____ LEFS _____

(The self-report measures have been developed based on instruments that were reviewed at the WCB Outcome Measures Workshop. The instruments chosen are based on body parts involved i.e. Roland Morris for thoracic and lumbar spine, Quick Dash for upper quadrant, and NDI for cervical spine and LEFS for lower quadrant injuries. It is mandatory to use the instruments described above. Please include the raw score for the initial measure when providing the information about the self-report measure)

17. Estimated physical restrictions include lifting (~ # of lbs .) _____ pushing/pulling (~ # of lbs) _____
 reaching overhead reaching turning walking _____ stairs ladders standing (~ # of hrs) _____
 sitting (~ # of hrs) _____ environment _____ other _____ (Provide the restrictions based on best clinical judgment and available information i.e. functional testing where appropriate. It does not ask for confirmed capacities but asks the practitioner to provide functional levels based on available information so that return to work parameters can be established.)

18. Effects of the injury may affect work activity for: # of days <7 _____ 8-14 15-21 RTW Date _____
(Based on your examination and management/treatment plan when would the worker be capable of Transitional or RTW)

19. Has RTW been discussed with the worker? Yes No the employer? Yes No

20. Has a RTW been arranged? Yes, RTW start date _____ No (Explain in Comments)

21. Are there any specific safety or medication concerns in a RTW? No Yes (If Yes, explain in Comments)

22. Comments _____

(Please use the comments section to include any concerns with the severity of injury, treatment, psychosocial or work issues which may delay recovery).

Signature _____ Date: d/m/y _____ Copy to _____

