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Chiropractic Report

05/2004

Initial Report	<input type="checkbox"/>
Progress Report	<input type="checkbox"/>
Discharge Summary	<input type="checkbox"/>

Please complete and return this form to the WCB. Attach additional pages, if necessary.

Section A Worker Information

Patient's name: _____ Claim #: _____
 Complete address: _____ Health card #: _____

 Sex: _____ Date of birth (dd/mm/yyyy): _____ Date of accident (dd/mm/yyyy): _____
 Employer name: _____
 Employer address: _____

Section B Medical History Refer to attached report As indicated below

1 Examination date (dd/mm/yyyy): _____ Initial examination date, if different (dd/mm/yyyy): _____ Treatments to date: _____
 2 Description of injury: _____
 3 Patient's symptoms: Acute Chronic Description: _____

Section C Examination Findings Refer to attached report As indicated below

4 Findings (include joint dysfunctions/subluxations): _____

 5 X-ray(s): Date (dd/mm/yyyy): _____ Facility: _____
 Findings: _____

 6 Diagnosis/impression: _____
 Prognosis: _____
 Expected return to work date (dd/mm/yyyy): _____ Complications or factors delaying recovery: _____

Section D Treatment Plan Refer to attached report Treatment unchanged As indicated below

7 Specific chiropractic manipulations/adjustments Exercise prescription Cryotherapy Ergonomic recommendations Modalities
 Explain (include rationale, expected outcomes, alternate approach if clinically indicated): _____

 8 Total treatments (initial estimate): _____ Frequency: _____ times per week for _____ weeks
 Additional treatments requested? Yes No If Yes, give number: _____
 9 Are any of the following required? Support or brace - Type: _____ Other requirements: _____
 10 Are any of the following required? Functional capacity evaluation Work conditioning Work hardening

Section E Worker Status Refer to attached report As indicated below

11 What type of work can be performed? (See attached.) Sedentary Light Medium Heavy Very heavy
 Describe additional work restrictions: _____
 12 Is this condition a recurrence of a previous work-related injury? Yes No
 If Yes, give date of previous injury (dd/mm/yyyy): _____ Old Claim Number: _____
 13 Had worker any previous physical defect? Yes No Not known If Yes, please specify: _____
 Has patient been discharged? Yes No If Yes, give date (dd/mm/yyyy): _____
 14 Comments: _____

Section F Certification

I certify that this is a complete and accurate report, and that I have read the reporting responsibilities attached to this form.

 Chiropractor's signature

 Date

WCB use only.	
Chiropractor's name _____	Contact code _____
Clinic name _____	Telephone _____
Street _____	Fax _____
Province/Postal Code _____	

Reporting Responsibilities:

This form must be completed legibly and submitted within three (3) business days after the patient's visit.

Work Capabilities and Definitions:

Sedentary Work

- Exerting up to 4.4 kg (10 lbs) of force occasionally and/or a negligible amount of force frequently.
- Sitting most of the time, or walking or standing for brief periods.

Light Work

- Exerting up to 8.9 kg (20 lbs) of force occasionally and/or up to 4.4 kg (10 lbs) frequently and/or negligible amounts frequently.
- Walking or standing to a significant degree, or sitting constantly with arm and/or leg controls requiring exertion of force greater than sedentary.

Medium Work

- Exerting up to 22.2 kg (50 lbs) of force occasionally and/or up to 8.9 kg (20 lbs) frequently and/or up to 4.4 kg (10 lbs) constantly.

Heavy Work

- Exerting up to 44.4 kg (100 lbs) of force occasionally and/or up to 22.2 kg (50 lbs) frequently and/or up to 8.9 kg (20 lbs) constantly.

Very Heavy Work

- Exerting in excess of 44.4 kg (100 lbs) of force occasionally and/or in excess of 22.2 kg (50 lbs) frequently and/or up to 8.9 kg (20 lbs) constantly.

Adapted from *The Medical Disability Advisor*, by Priestley Reed, MD, LRP Publications.

Symptom Description:

Acute

- A health state or health effect of short duration—sometimes meaning severe.

Chronic

- A health state lasting a long time. The US National Centre for Health Statistics defines a "chronic" condition as one of three months duration or longer.