Workers Compensation Board of Manitoba

Please FAX this form IMMEDIATELY
Winnipeg: 954-4999
Toll free: 1-877-872-3804
333 Broadway • Winnipeg R3C 4W3
Telephone 954-4922 • Toll free 1-800-362-3340

CHIROPRACTOR FIRST REPORT

Claim No.

4C

Worker Information

Last Name	First Name	Address	
City	Province	Postal Code	Telephone No. ( )

Gender	Height	Weight	Date of Birth DD / MM / YYYY	PHIN _ _ _-_ _ _-_ _ _	Job Title

Employer Information

Name		Address
City	Province	Postal Code

Injury Details

Date of Incident DD / MM / YYYY	Indicate Area of Injury Back: ☐ Cervical ☐ Thoracic ☐ Lumbar Sacral	Extremity:	Other:
Worker's description of incident or injury			

Examination Findings & Diagnosis

Date of Examination DD / MM / YYYY	Diagnosis

Subjective Complaints

Objective Findings (include ROM, muscle testing & neurological status)

Tests performed (e.g. X-Ray) Attach results	Location	Date of Appointment(s) DD / MM / YYYY DD / MM / YYYY

Category of injury (please check one)

	Symptomatic	Loss of Mobility	Complicated
Spinal	☐	☐	☐
Extremity	☐	☐	☐

Rationale Supporting Category
☐ Multiple injuries to same site
☐ Age over 55
☐ Other_____

Treatment Plan

Type, frequency and duration

☐ Adjustment/SMT (freq.____x/wk.; dur.____/wks.)
☐ Adjunctive Therapy (freq.____x/wk.; dur.____/wks.)
☐ Active Rehab (freq.____x/wk.; dur.____/wks.)
☐ Other _____ (freq.____x/wk.; dur.____/wks.)

Date of Next Visit DD / MM / YYYY

Work Capabilities

Will Worker be disabled from work beyond the date of incident as a result of the injury? ☐ yes ☐ no

When can Worker return to regular duties?
Date DD / MM / YYYY ☐ Unknown at time of examination

Is Worker capable of alternate or modified work? ☐ yes ☐ no

Duration of restrictions: _____weeks

If yes, outline restrictions

Chiropractor Information

Chiropractor Name	Telephone No. ( )	Fax No. ( )
Address	Chiropractor Signature	Date DD / MM / YYYY
City / Province / Postal Code		

WCB 4098

Aussi disponible en français

Fax This Form Winnipeg: 954-4999
Toll Free: 1-877-872-3804