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

Physiotherapy Initial Assessment

Claim No.

Worker Information

Last Name			First Name			
Address			City	Province	Postal Code	Telephone No. ( )
Date of Birth DD / MM / YYYY	Job Title				Name of Attending/Referring Physician	

Injury Details

Date of Incident DD / MM / YYYY	Area of Injury	Request for discussion with WCB Physiotherapy Consultants? ☐ Yes ☐ No
Date of Initial Assessment DD / MM / YYYY	Worker's description of incident or injury	

Examination Findings & Diagnosis

Current Subjective Complaints

Self Assessment Tool (check tools used - minimum of 2)

Tool	Score:	Tool	Score:
☐ Numeric Pain Rating Scale (NPRS)	______	☐ Lower Extremity Activity Profile (LEFS)	_______
☐ Roland Morris Back Pain Questionnaire (back)	______	☐ Disabilities of the Arm, Shoulder and Hand (DASH)	_______
☐ Neck Disability Index (neck)	______	☐ Health Status Disability	_______

Current Objective Findings - Impairments Specify:

Mobility ☐ Yes ☐ No

Strength ☐ Yes ☐ No ☐ /5 If yes, specify muscle groups involved

Other (ligamentous, stability, edema, gait, neurological, etc) ☐ Yes ☐ No
If yes, specify:

Therapist's Diagnosis on Completion of Assessment

Multisite request x _____ visits
(If approved requires scheduling double the normal allotted treatment time)

Anticipated treatment _______ /week x _______ weeks

Were findings/recommendations discussed with worker? ☐ Yes ☐ No

Was home program provided? ☐ Yes ☐ No If yes, specify:

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
If yes, outline restrictions:

Duration of restrictions: _______ weeks

Therapist Information

Therapist Name			Telephone No. ( )		Fax No. ( )
Facility Name			Email	Date DD / MM / YYYY	
City	Province	Postal Code	Therapist Signature		

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