WCB Workers Compensation Board of Manitoba

Phone 204-954-4321
(Toll free 1-855-954-4321)
333 Broadway, Winnipeg R3C 4W3
wcb.mb.ca

Chiropractor First Report

Claim Number	4C

Worker Information

Last Name		First Name	
Address		City	Province
Postal Code	Phone Number	Gender	PHIN
Height	Weight	Date of Birth (dd/mm/yyyy)	Job Title

Employer Information

Name	Address	
City	Province	Postal Code

Injury Details

Date of incident	Indicate area of injury Back: ☐Cervical ☐Thoracic ☐Lumbar Sacral	Extremity:	Other:

Worker's description of incident or injury: _____

Examination Findings and Diagnosis

Date of Examination	Diagnosis
Subjective Complaints	
Objective Findings (include ROM, muscle testing & neurological status)	
Tests performed (e.g. X-Ray) Attach results/dates:	Multisite request x _____ visits Please confirm 2nd area of injury and proposed treatment:

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 (frequency____x/wk.; duration____/wks.) ☐Active Rehab (frequency____x/wk.; duration____/wks.)

☐Adjunctive Therapy (frequency____x/wk.; duration xq /wks.) ☐Other _____ (frequency____x/wk.; duration____/wks.)

Date of Next Visit

Work Capabiliites

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

Is worker capable of alternate or modified work? ☐Yes ☐No If yes, outline restrictions: ☐Unknown at time of examination

Duration of restrictions
weeks

Chiropractor Information

Chiropractor Name	Address		
Chiropractor Signature	City	Province	Postal Code
	Phone Number	Fax Number	Date

WCB 4036

Fax this form - in Winnipeg: 204-954-4999 | toll free: 1-877-872-3804