

Claim Number	<b>4C</b>
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## 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: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbo-Sacral	Extremity:	Other:
Worker's description of incident or injury: _____ _____			

## Examination Findings and Diagnosis

Date of Examination	Diagnosis														
Subjective Complaints, including Pain Levels (VAS)															
Objective Findings (include ROM, muscle testing, neurological status, x-ray, status inventory scores) - Attach results:															
Category of Injury (please check one)	Rationale Supporting Category		Multisite request x _____ visits Please confirm 2nd area of injury and proposed treatment:												
<table border="0"> <tr> <td></td> <td>Symptomatic</td> <td>Loss of Mobility</td> <td>Complicated</td> </tr> <tr> <td>Spinal</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> <tr> <td>Extremity</td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> <td><input type="checkbox"/></td> </tr> </table>		Symptomatic	Loss of Mobility	Complicated	Spinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> Multiple injuries to same site <input type="checkbox"/> Age over 55 <input type="checkbox"/> Other _____		
	Symptomatic	Loss of Mobility	Complicated												
Spinal	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												
Extremity	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>												

## Treatment Plan

Type, frequency and duration of in-clinic treatment
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## Exercise Program

Date to be Initiated: _____ (frequency ___x/wk.; duration ___wks.)
<input type="checkbox"/> CCGI or equivalent <input type="checkbox"/> In-clinic demonstration <input type="checkbox"/> Supportive material provided <input type="checkbox"/> Copy of program attached

## Work Abilities

Will worker be restricted from work beyond the date of incident as a result of the injury? <input type="checkbox"/> Yes <input type="checkbox"/> No	When can worker return to regular duties? Date
Is worker capable of modified or alternate duties? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, outline restrictions:	Duration of restrictions _____ weeks
<input type="checkbox"/> Sedentary: Ability to sit up to six hours in an eight hour work day, lift light objects such as files and paperwork frequently during the day and objects weighing up to 10 pounds occasionally during the day. <input type="checkbox"/> Light: Ability to stand up to six hours in an eight hour work day, lift up to 10 pounds frequently and up to 20 pounds occasionally. <input type="checkbox"/> Medium: Ability to stand up to six hours in an eight hour work day, lift up to 25 pounds frequently and up to 50 pounds occasionally. <input type="checkbox"/> Heavy: Same standing as light and medium, lifting heavier than medium.	

## Chiropractor Information

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