

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: <input type="checkbox"/> Cervical <input type="checkbox"/> Thoracic <input type="checkbox"/> 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)		Rationale Supporting Category
Spinal	<input type="checkbox"/> Symptomatic <input type="checkbox"/> Loss of Mobility <input type="checkbox"/> Complicated	<input type="checkbox"/> Multiple injuries to same site
Extremity	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> Age over 55
		<input type="checkbox"/> Other _____

Treatment Plan

Type, frequency and duration <input type="checkbox"/> Adjustment/SMT (freq. ___x/wk.; dur. ___/wks.) <input type="checkbox"/> Adjunctive Therapy (freq. ___x/wk.; dur. ___/wks.)	<input type="checkbox"/> Active Rehab (freq. ___x/wk.; dur. ___/wks.) <input type="checkbox"/> Other _____ (freq. ___x/wk.; dur. ___/wks.)	Date of Next Visit DD / MM / YYYY
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Work Capabilities

Will Worker be disabled 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 DD / MM / YYYY <input type="checkbox"/> Unknown at time of examination
Is Worker capable of alternate or modified work? <input type="checkbox"/> yes <input type="checkbox"/> no	Duration of restrictions: _____ weeks
If yes, outline restrictions	

Chiropractor Information

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