

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

## Treatment Plan

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

## Work Abilities

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
Is worker capable of alternate or modified work? <input type="checkbox"/> Yes <input type="checkbox"/> No    If yes, outline restrictions:	<input type="checkbox"/> 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