Chiropractic Initial Report

Lock

If applicable, please select the Lock button before submitting the form.
Please note: once the Lock button has been selected, the form will no longer be editable.

INVOICE INFORMATION			
CLAIM NUMBER	DATE OF ACCIDENT (dd/mmm/yyyy)	DATE OF REPORT (dd/mmm/yyyy)	VENDOR NUMBER
INVOICE/REFERENCE NUMBER	PAYEE NAME		
PAYEE ADDRESS			
PAYEE ADDRESS			

PATIENT INFORMATION			
FIRST NAME	LAST NAME	DATE OF BIRTH (dd/mmm/yyyy)	PERSONAL HEALTH NUMBER (PHN)

PRACTITIONER INFORMATION		
FIRST NAME	LAST NAME	PRACTITIONER NUMBER

Assessment

DATE OF ASSESSMENT (dd/mmm/yyyy)	DATE OF ASSESSMENT (dd/mmm/yyyy)	DATE OF ASSESSMENT (dd/mmm/yyyy)	DATE OF ASSESSMENT (dd/mmm/yyyy)

Work Status

1. IS THE PATIENT STILL JOB ATTACHED?
◯ Yes ◯ No

2. IS THE PATIENT EMPLOYED OR ENGAGED IN TRAINING ACTIVITIES? PLEASE INDICATE WHICH ONE(S)
☐ Full time ☐ Part time ☐ Self-employed ☐ Seasonal ☐ Training/Apprenticeship ☐ Student ☐ Retired ☐ Not employed

3. HAS THE PATIENT BEEN ABSENT FROM THE FOLLOWING AS A RESULT OF THE MVA?
Work: ◯ Yes ◯ No Training: ◯ Yes ◯ No School/Studies: ◯ Yes ◯ No

If the patient is continuing to work, study or train indicate their status, as applicable

4. STATUS OF DUTIES
Work: ◯ Full ◯ Modified Training: ◯ Full ◯ Modified Study: ◯ Full ◯ Modified

5. STATUS OF HOURS
Work: ◯ Full ◯ Modified Training: ◯ Full ◯ Modified Study: ◯ Full ◯ Modified

Return to Work Planning

Only fill this section, "Return to Work Planning", if the patient was gainfully employed on the date of the accident and is not currently working, or working for modified hours/ duties.

6. WHAT IS THE PATIENT'S CURRENTLY RECOMMENDED RETURN TO WORK STATUS?
◯ Full work status ◯ Modified work ◯ Not recommended to return to work in any capacity

IF MODIFIED WORK, SPECIFY WHAT MODIFICATION:
☐ Modified hours ☐ Modified duties

If the patient is not recommended to return to work in any capacity, fill out Questions 7 and 8.

7. WHEN CAN RETURN TO WORK COMMENCE? PLEASE PROVIDE DETAILS:

8. ADDITIONAL RECOMMENDATION(S) ON RETURN TO WORK

Activities of Daily Living (ADL)

REPORTS OF ISSUES RELATED TO ADLs

Assessment Findings

SIGNIFICANT SUBJECTIVE FINDINGS

SIGNIFICANT OBJECTIVE FINDINGS

9. PALPATORY TENDERNESS
○ Yes ○ No

If 'Yes' on Question 9, fill out at least one of the Questions 10, 11, or 12 .

10. CERVICAL SPINE	☐ Left ☐ Midline ☐ Right
11. THORACIC SPINE	☐ Left ☐ Midline ☐ Right
12. LUMBAR SPINE	☐ Left ☐ Midline ☐ Right

13. STRAIGHT LEG RAISE LIMITED
○ Yes ○ No

IF YES, WHICH SIDE?
☐ Left ☐ Right

AROM/PROM LIMITATIONS

14. CERVICAL
○ Yes ○ No

IF YES, PROVIDE COMMENTS:

15. THORACIC
○ Yes ○ No

IF YES, PROVIDE COMMENTS:

16. LUMBAR
○ Yes ○ No

IF YES, PROVIDE COMMENTS:

NEUROLOGICAL EXAM	
17. SENSORY DEFICIT ○ Yes ○ No	IF YES, WHERE? ☐ Left arm ☐ Left leg ☐ Right arm ☐ Right leg
18. MOTOR WEAKNESS ○ Yes ○ No	IF YES, WHERE? ☐ Left arm ☐ Left leg ☐ Right arm ☐ Right leg
19. DEEP TENDON REFLEX DEFICITS ○ Yes ○ No	IF YES, WHERE? ☐ Left arm ☐ Left leg ☐ Right arm ☐ Right leg

20. DEGENERATIVE CHANGES ○ Yes ○ No
IF YES, SPECIFY LEVELS:

21. FRACTURE DISLOCATION ○ Yes ○ No
IF YES, SPECIFY LEVELS:

MEDICAL INVESTIGATION(S)

Objective Measures

OBJECTIVE MEASURE

Chiropractic Diagnosis

DIAGNOSIS 1		
CATEGORY		INJURY
SEVERITY	BODY PART	ORIENTATION

DIAGNOSIS 2		
CATEGORY		INJURY
SEVERITY	BODY PART	ORIENTATION

DIAGNOSIS 3		
CATEGORY		INJURY
SEVERITY	BODY PART	ORIENTATION

DIAGNOSIS 4		
CATEGORY		INJURY
SEVERITY	BODY PART	ORIENTATION

DIAGNOSIS 5		
CATEGORY		INJURY
SEVERITY	BODY PART	ORIENTATION

First Treatment

TREATMENT MODALITY (If applicable)

22. REFERRAL TO ADDITIONAL MEDICAL INVESTIGATION(S)

○ Yes ○ No

IF YES, IDENTIFY:

Treatment

TREATMENT GOALS (AT LEAST 1)
TREATMENT GOAL 1
TREATMENT GOAL 2
TREATMENT GOAL 3

TREATMENT PLAN

Communication Request

23. DO YOU WISH TO HAVE A PHONE CONSULT WITH THE CLAIM FILE HANDLER?

○ Yes ○ No

24. DO YOU WISH TO HAVE A PHONE CONSULT WITH OTHER CLINICIANS INVOLVED IN THIS PATIENT'S CARE?

○ Yes ○ No

IF YES, SPECIFY WHICH ONES:

☐ By checking this box, I certify that the information provided is true and correct to the best of my knowledge.

Select one of the following:

☐ I have obtained consent from the patient to share all information related to the history, examination, assessment and management of the injury related to the motor vehicle accident with ICBC.

☐ This report is being provided pursuant to a request by ICBC under Section 28 or Section 28.1 of the *Insurance (Vehicle) Act*.

Personal information on this form is being collected under Section 26 of the *Freedom of Information and Protection of Privacy Act (BC)* and Section 28 or 28.1 of the *Insurance (Vehicle) Act (BC)* for the purpose of obtaining a health care report in order to investigate, manage or settle a claim. Questions about the collection of this information may be directed to the adjuster, or call 604-661-2800 or contact the Privacy & Freedom of Information (FOI) Department at 151 W Esplanade, North Vancouver, BC V7M 3H9.