wcb Workers' Compensation Board – Alberta

P.O. BOX 2415
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C056
CHIRO FIRST REPORT

WORKER DETAILS

		WCB Claim Number
Surname	First Name and Initial	Date of Birth: *(Year / Month / Day)*
Address: *Apt/Unit* *Street*	*City/Town*	*Province*
Postal Code:	Gender: ☐ Male ☐ Female	Telephone Number:

Worker's Job Title/Occupation:	Progressive Injury? ☐ Yes ☐ No	Date of Injury: *(Year / Month / Day)*
Describe how and when the injury/condition occurred.		Date of Exam: *(Year / Month / Day)*

Examination
Symptoms:

Objective Findings:

Diagnosis:

Diagnostic Code 1:	Diagnostic Code 2:	Diagnostic Code 3:

Part of body:	Side of Body:	Nature of Injury:

Are you aware of any prior conditions in the same anatomical area? ☐ Yes ☐ No If yes, describe

Was any diagnostic imaging completed (X-ray, etc)? ■ Yes ☐ No	Was the diagnostic imaging completed within your clinic? ■ Yes ☐ No
Diagnostic imaging type:	Diagnostic imaging facility:

Diagnostic imaging interpretation — Diagnostic imaging date *(Year / Month / Day)*

Treatment Plan:

Frequency and Duration:

THIS DOCUMENT MAY BE EXAMINED BY ANY PERSON WITH DIRECT INTEREST IN A CLAIM THAT IS UNDER REVIEW.

Any complicating factors affecting recovery? ☐ Yes ☐ No If yes, describe

WCB assisted services required?
☐ Contact with WCB case manager ☐ Contact with WCB WCB chiropractic consultant ☐ Referral to Return to Work provider

Treatment Complete ☐ Yes ☐ No If yes, discharge recommendations

Has the worker missed work beyond the date of accident? ☐ Yes ☐ No

Has the patient returned to work? ☐ Yes ☐ No If yes, Date *(Year / Month / Day)*

If returned to work, what is the worker's current work status? ☐ Full duties and hours ☐ Modified Hours _____ ☐ Modified duties

Job Requirements:

If patient is currently not working or is working modified duties, complete the following.
Please make a selection below as they relate to the injury:

Sitting	☐ Able	☐ Unable	☐ Limited to ____ Hours
Standing	☐ Able	☐ Unable	☐ Limited to ____ Hours
Walking	☐ Able	☐ Unable	☐ Limited to ____ Hours
Bending	☐ Able	☐ Unable	☐ Limited
Twisting	☐ Able	☐ Unable	☐ Limited
Kneeling/squatting	☐ Able	☐ Unable	☐ Limited

Climbing	☐ Able	☐ Unable	☐ Limited
Lifting	☐ Able	☐ Unable	☐ Limited, Max of _____ (lbs/kg)
Pushing / pulling	☐ Able	☐ Unable	☐ Limited
Overhead reaching	☐ Able	☐ Unable	☐ Limited
Driving	☐ Able	☐ Unable	☐ Limited to ____ Hours

Other reasons why the patient cannot work:
☐ Hospitalized ☐ Self reported pain ☐ Opioids/Medication side effects

Other restrictions or additional comments/special considerations:

☐ Estimated Return to Work to pre-accident work date *(Year / Month / Day)* or ☐ permanent restrictions anticipated

Name and address to whom fee is payable: (please print)	Provider's Signature:	Printed Name:
	Provider's Reference Number	Date *(Year / Month / Day)*
	Telephone Number	Fax Number