✓ To fill in and save this PDF, use Adobe Acrobat Reader XI or later.

Chiropractic Progress 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)	NUMBER OF TREATMENT SESSIONS TO DATE
DATE OF PREVIOUS ASSESSMENT (dd/mmm/yyyy)	DATE OF FIRST VISIT (dd/mmm/yyyy)

Work Status

	PRE-ACCIDENT EMPLOYMENT/TRAINING	PRE-ACCIDENT STATUS	CURRENT EMPLOYMENT/TRAINING	CURRENT STATUS
PRIMARY STATUS				
SECONDARY STATUS				
TERTIARY STATUS				

Comments

PROVIDE ADDITIONAL COMMENTS ON WORK STATUS, AS RELEVANT

Return to Work Planning

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

1. 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 2 and 3.

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

3. RECOMMENDATION(S) ON RETURN TO WORK

Activities of Daily Living (ADL)

REPORTS OF ISSUES RELATED TO ADLs

Assessment Findings

SIGNIFICANT SUBJECTIVE FINDINGS

RELEVANT PRE-ACCIDENT HISTORY

4. HAS YOUR PATIENT EVER HAD SYMPTOMS AND/OR RECEIVED TREATMENT/MEDICATIONS FOR THE AREA(S) INJURED IN THIS ACCIDENT?

○ Yes ○ No

IF YES, DESCRIBE CONDITIONS/TREATMENT AND POSSIBLE IMPACT, IF ANY, ON RECOVERY:

SIGNIFICANT OBJECTIVE FINDINGS

5. PALPATORY TENDERNESS

○ Yes ○ No

If 'Yes' on Question 5, fill out at least one of the Questions 6, 7, or 8.

6. CERVICAL SPINE	☐ Left ☐ Midline ☐ Right
7. THORACIC SPINE	☐ Left ☐ Midline ☐ Right
8. LUMBAR SPINE	☐ Left ☐ Midline ☐ Right

9. STRAIGHT LEG RAISE LIMITED

○ Yes ○ No

IF YES, WHICH SIDE?

☐ Left ☐ Right

AROM/PROM LIMITATIONS

10. CERVICAL

○ Yes ○ No

PREVIOUS ASSESSMENT FINDINGS	CURRENT ASSESSMENT FINDINGS

11. THORACIC
○ Yes ○ No

PREVIOUS ASSESSMENT FINDINGS	CURRENT ASSESSMENT FINDINGS

12. LUMBAR
○ Yes ○ No

PREVIOUS ASSESSMENT FINDINGS	CURRENT ASSESSMENT FINDINGS

NEUROLOGICAL EXAM

13. SENSORY DEFICIT ○ Yes ○ No	IF YES, WHERE? ☐ Left arm ☐ Left leg ☐ Right arm ☐ Right leg
14. MOTOR WEAKNESS ○ Yes ○ No	IF YES, WHERE? ☐ Left arm ☐ Left leg ☐ Right arm ☐ Right leg
15. DEEP TENDON REFLEX DEFICITS ○ Yes ○ No	IF YES, WHERE? ☐ Left arm ☐ Left leg ☐ Right arm ☐ Right leg

16. DEGENERATIVE CHANGES
○ Yes ○ No

IF YES, SPECIFY LEVELS:

17. FRACTURE DISLOCATION
○ Yes ○ No

IF YES, SPECIFY LEVELS:

MEDICAL INVESTIGATION(S)

Objective Measures

PREVIOUS ASSESSMENT FINDINGS	CURRENT ASSESSMENT FINDINGS

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

Treatment

TREATMENT PROGRESS
DESCRIBE TREATMENT PROGRESS TO DATE

UPDATED CLIENT-SPECIFIC GOALS
GOAL 1
GOAL 2
GOAL 3

UPDATED CLINICAL/REHAB-SPECIFIC GOALS
GOAL 1
GOAL 2
GOAL 3

BARRIERS TO RECOVERY
BARRIER 1
BARRIER 2
BARRIER 3

UPDATED TREATMENT PLAN			
NUMBER OF TREATMENT SESSIONS BEING RECOMMENDED	LENGTH OF TREATMENT SESSIONS IN MINUTES	FREQUENCY OF TREATMENT SESSIONS	ANTICIPATED DISCHARGE DATE (ddmmmyyyy)
ADDITIONAL INFORMATION			

Communication Request

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

○ Yes ○ No

19. 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 manage the claim. Questions about the collection of this information may be directed to the claim representative, or call 604-661-2800 or contact the Privacy & Freedom of Information department at 151 Esplanade, North Vancouver, BC V7M 3H9.