CC - CHIEF COMPLAINT:

C/S - CERVICAL SPINE | L/S - LUMBAR SPINE | T/S - THORACIC SPINE | HA - HEADACHE
SH - SHOULDER | PELV - PELVIS | KN - KNEE | EXT - EXTREMITIES

DATE	CC	B - BETTER W - WORSE S - SAME	T/S	L/S	PELVIC	CERV.	ATLAS	EXT.	F.O.P.	$	CHIRO	MT	NATURO
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WCB Visit Checklist

Patient Name: _____

Date of Injury: _____

Claim Number: _____

Employer: _____

Phone: _____ Fax: _____

6 Weeks from Initial Exam Date: _____

AUTHORIZATION	FORM	COMPLETED	ONLINE	COMPLETED
Yes	Worker's Report		First Report	
No	WCB Injury Form		Progress Report	
Date:	Payment Agreement		Invoice	

Initial Exam Date: _____ Billing Amount: _____ WAD: _____

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

File must be places on docs desk after Initial Exam.

First Report must be submitted within 24 hours of the Initial Exam.

WCB does not cover massage therapy.

If the patient has missed three appointments, cancelled without 24 hours notice or does not comply with their recommended treatment schedule, WCB will close their case.

Progress Report must be submitted at the end of the third week.

22. _____ 14. _____ 6. _____

21. _____ 13. _____ 5. _____

20. _____ 12. _____ 4. _____

19. _____ 11. _____ 3. _____

18. _____ 10. _____ 2. _____

17. _____ 9. _____ 1. _____

16. _____ 8. _____

15. _____ 7. _____ EXP. DATE _____

The Chiropractic Center for Health

PAYMENT AUTHORIZATION REGARDING WCB CLAIMS

Please note that on the occasion that WCB does not authorize your claim, it is your responsibility as our patient to pay for your chiropractic treatments.

As well, in the case that a total of three appointments are cancelled or an appointment is missed without 24 hours notice, treatment will be suspended until further review by your WCB Case Worker.

Name:_____

Signed:_____

Date:_____

Witness:_____

Alberta Health Care Number: _____

WCB Claim Number: _____

Low Back Pain And Disability Questionnaire (Revised Oswestery)

Patient Name: _____ Date: _____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in every day life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

SECTION 1 – PAIN INTENSITY
- ❑ The pain comes and goes and is very mild.
- ❑ The pain is mild and does not vary much.
- ❑ The pain comes and goes and is moderate.
- ❑ The pain comes and goes and is severe.
- ❑ The pain is severe and does not vary much.

SECTION 2- PERSONAL CARE
- ❑ I would not have to change my way of washing or dressing in order to avoid pain.
- ❑ I do not normally change my way of washing or dressing even though it causes pain.
- ❑ Washing and dressing increases the pain but I manage not to change my way of doing it.
- ❑ Because of the pain I am unable to do some washing and dressing without help.
- ❑ Because of the pain I am unable to do any washing and dressing without help.

SECTION 3 – LIFTING
- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it causes extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned (i.e. on the table).
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can only lift very light weights at the most.

SECTION 4 – WALKING
- ❑ I have no pain when walking.
- ❑ I have some pain when walking but it does not increase with distance.
- ❑ I cannot walk more than one km. without increasing pain.
- ❑ I cannot walk more than ½ km. without increasing pain.
- ❑ I cannot walk more than ¼ km. without increasing pain.
- ❑ I cannot walk at all without increasing pain.

SECTION 5 – SITTING
- ❑ I can sit in any chair as long as I like.
- ❑ I can only sit in my favorite chair as long as I like.
- ❑ Pain prevents me from sitting for more then one hour.
- ❑ Pain prevents me from sitting more then a half hour.
- ❑ Pain prevents me from sitting more then 10 minutes.
- ❑ I avoid sitting because it increases pain immediately.

SECTION 5 – STANDING
- ❑ I can stand as long as I want without pain.
- ❑ I experience some pain while standing but it does not increase with time.
- ❑ I cannot stand for longer than one hour without increasing pain.
- ❑ I cannot stand for longer then ½ hour without increasing pain.
- ❑ I cannot stand for longer than 10 minutes without increasing pain.
- ❑ I avoid standing because it increases the pain immediately.

SECTION 7 – SLEEPING
- ❑ I experience no pain in bed.
- ❑ I experience pain in bed but it does not prevent me from sleeping well.
- ❑ Because of pain my normal night's sleep is reduced by less than ¼.
- ❑ Because of pain my normal night's sleep is reduced by less than ½.
- ❑ Because of pain my normal night's sleep is reduced by less than ¾.
- ❑ Pain prevents me from sleeping at all.

SECTION 8 – SOCIAL LIFE
- ❑ My social life is normal and gives me no pain.
- ❑ My social life is normal but increases the degree of pain.
- ❑ Pain has no significant effect on my social life apart from limiting my more energetic interests (i.e. dancing, etc.)
- ❑ Pain has restricted my social life and I do not go out very often.
- ❑ Pain has restricted my social life to my home.
- ❑ I have hardly any social life because of the pain.

SECTION 9 – TRAVELING
- ❑ I experience no pain while traveling.
- ❑ I experience some pain while traveling but none of my usual forms of travel make it any worse.
- ❑ I experience extra pain while traveling but it does not compel me to seek alternative forms of travel.
- ❑ I experience extra pain while traveling which compels me to seek alternative forms of travel.
- ❑ Pain restricts all forms of travel.
- ❑ Pain prevents all forms of travel except that done lying down.

SECTION 10 – CHANGING DEGREE OF PAIN
- ❑ My pain is rapidly getting better.
- ❑ My pain fluctuates but overall is definitely getting better.
- ❑ My pain seems to be getting better but improvement is slow at present.
- ❑ My pain is neither getting better nor worse.
- ❑ My pain is gradually worsening.
- ❑ My pain is rapidly worsening.

Pain Scale (Rate the severity of your pain by checking one box on the following scale):

No Pain **Excruciating Pain**

0	1	2	3	4	5	6	7	8	9	10

Neck Pain And Disability Index (Vernon-Mior)

Patient Name: _____ Date: _____

Please read instructions:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in every day life. Please answer every section and mark in each section only the **ONE** box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

SECTION 1 – PAIN INTENSITY

- ❑ I have no pain at the moment.
- ❑ The pain is very mild at the moment.
- ❑ The pain is moderate at the moment.
- ❑ The pain is fairly severe at the moment.
- ❑ The pain is very severe at the moment.
- ❑ The pain is the worst imaginable at the moment.

SECTION 2 – PERSONAL CARE (Washing, Dressing, etc)

- ❑ I can look after myself normally without causing extra pain.
- ❑ I can look after myself normally but it causes extra pain.
- ❑ It is painful to look after myself and I am slow and careful.
- ❑ I need some help but manage most of my personal care.
- ❑ I need help every day in most aspects of self-care.
- ❑ I do not get dressed, I wash with difficulty and stay in bed.

SECTION 3 – LIFTING

- ❑ I can lift heavy weights without extra pain.
- ❑ I can lift heavy weights but it causes extra pain.
- ❑ Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on the table.
- ❑ Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned.
- ❑ I can lift very light weights.
- ❑ I cannot lift or carry anything at all.

SECTION 4 – READING

- ❑ I can read as much as I want to with no pain in my neck.
- ❑ I can read as much as I want to with slight pain in my neck.
- ❑ I can read as much as I want to with moderate pain in my neck.
- ❑ I can't read as much as I want because of moderate pain in my neck.
- ❑ I can hardly read at all because of severe pain in my neck.
- ❑ I cannot read at all.

SECTION 5 – HEADACHES

- ❑ I have no headaches at all.
- ❑ I have slight headaches which come infrequently.
- ❑ I have moderate headaches which come infrequently.
- ❑ I have moderate headaches which come frequently.
- ❑ I have severe headaches which come frequently.
- ❑ I have headaches almost all the time.

SECTION 6 – CONCENTRATION

- ❑ I can concentrate fully when I want to with no difficulty.
- ❑ I can concentrate fully when I want to with slight difficulty.
- ❑ I have fair degree of difficulty in concentrating when I want to.
- ❑ I have a lot of difficulty in concentrating when I want to.
- ❑ I have a great deal of difficulty in concentrating when I want to.
- ❑ I cannot concentrate at all.

SECTION 7 – WORK

- ❑ I can do as much work as I want to.
- ❑ I can only do my usual work, but no more.
- ❑ I can do most of my usual work, but no more.
- ❑ I cannot do my usual work.
- ❑ I can hardly do any work at all.
- ❑ I can't do any work at all.

SECTION 8 – DRIVING

- ❑ I can drive my car without any neck pain.
- ❑ I can drive my car as long as I want with slight pain in my neck.
- ❑ I can drive my car as long as I want with moderate pain in my neck.
- ❑ I can't drive my car as long as I want because of moderate pain in my neck.
- ❑ I can hardly drive at all because of severe pain in my neck.
- ❑ I can't drive my car at all.

SECTION 9 – SLEEPING

- ❑ I have no trouble sleeping.
- ❑ My sleep is slightly disturbed (less than 1 hr. sleepless).
- ❑ My sleep is mildly disturbed (1-2 hrs. sleepless).
- ❑ My sleep is moderately disturbed (2-3 hrs. sleepless).
- ❑ My sleep is greatly disturbed (3-5 hrs. sleepless).
- ❑ My sleep is completely disturbed (5-7 hrs. sleepless).

SECTION 10 – RECREATION

- ❑ I am able to engage in all my recreation activities with no neck pain at all.
- ❑ I am able to engage in all my recreation activities, with some pain in my neck.
- ❑ I am able to engage in most, but not all of my usual recreation activities because of pain in my neck.
- ❑ I am able to engage in a few of my usual recreation activities because of pain in my neck.
- ❑ I can hardly do any recreation activities because of pain in my neck
- ❑ I can't do any recreation activities at all.

Pain Scale (Rate the severity of your pain by checking one box on the following scale):

No Pain **Excruciating Pain**

0	1	2	3	4	5	6	7	8	9	10

WCB PERSONAL INJURY – PATIENT DATA FORM

Date: _____
Name (Surname, First, Middle): _____
Date of Birth: _____
Home Address: _____
Phone Number: _____
Alberta Health Care Number: _____
Claim Number: _____

In order for your claim to go though, it is imperative that you be as specific as possible.

1. Date of Accident: _____
2. Time: _____(AM/PM)
3. Location: _____
4. Occupation: _____
   Employer: _____
   Employers Address: _____
   Employers Phone Number: _____
   Please list specific job requirements: _____
   _____
5. Have you missed time from work? Yes/No
6. If yes, Full-time off work: dates _____ to _____
   Part-time off work: dates _____ to _____
7. Have you been unable to work since the accident/injury? Yes/No
   _____
8. Describe in your own words what happened to you at the time of your injury:
   _____
9. What bleeding cuts did you get from the accident?_____
10. What bruises did you get from the accident?_____
11. Please describe how you felt: (Be specific)
    a) ***Immediately after the injury:***

_____
_____
_____

    b) ***Later that _____ Day _____ Night:***

_____
_____
_____

    c) ***The next _____ Day _____ Days:***

12. Check symptoms that are apparent ***since*** the accident:

( ) headache	( ) loss of smell	( ) numbness in fingers
( ) neck pain/stiffness	( ) loss of taste	( ) cold hands
( ) mid back pain	( ) loss of memory	( ) cold feet
( ) low back pain	( ) fatigue	( ) diarrhea
( ) eyes sensitive to light	( ) tension	( ) constipation
( ) pain behind eyes	( ) shortness of breath	( ) chest pain
( ) dizziness	( ) irritability	( ) nervousness
( ) fainting	( ) depression	( ) cold sweats
( ) ringing/buzzing ears	( ) sleeping problems	( ) anxious
( ) loss of balance	( ) numbness in toes	

( ) other _____

13. Did you seek medical help immediately/soon after the accident? Yes/No
14. If yes, how did you get there?

( ) someone else drove me	( ) ambulance
( ) drove own car	( ) police

( ) other _____

15. ***DOCTOR 1/HOSPTIAL/CLINIC SEEN:*** _____ date _____
16. Were you examined? Yes/No
17. Were X-rays taken? Yes/No
18. If yes, of what body parts?

_____

19. What treatment was given to you?

( ) bed rest	( ) brace	( ) physiotherapy
( ) adjustments	( ) medications	( ) other _____

20. What benefits did you receive from the treatment?

_____

_____

21. Date of last treatment: _____
22. ***DOCTOR 2/HOSPTIAL/CLINIC SEEN:*** _____ date _____
23. Were you examined? Yes/No
24. Were X-rays taken? Yes/No
25. If yes, what body parts? _____
26. What treatment was given to you?

( ) bed rest	( ) brace	( ) physiotherapy
( ) adjustments	( ) medications	( ) other _____

27. What benefits did you receive from the treatment?

_____

_____

28. Date of last treatment: _____
29. ***DOCTOR 3/HOSPTIAL/CLINIC SEEN:*** _____ date _____
30. Were you examined? Yes/No
31. Were X-rays taken? Yes/No

32. If yes, what body parts? _____

33. What treatment was given to you?
( ) bed rest ( ) brace ( ) physiotherapy
( ) adjustments ( ) medications ( ) other _____

34. What benefits did you receive from the treatment?

_____

_____

35. Date of last treatment: _____

36. Did you have any physical complaints ***just before the accident***? Yes/No

37. If yes, please explain in detail:

_____

_____

38. ***Prior*** to this accident, have you ***ever*** had symptoms similar to what you're experiencing now? Yes/No

39. If yes, please explain:

_____

_____

_____

(briefly include past falls, injuries, motor vehicle accidents, operations, etc.)

40. Do you notice any activities of your home daily routine that are different ***now*** than from ***before*** the accident? Yes/No

41. Do you notice any activities of your work daily routine that are different ***now*** than from ***before*** the accident? Yes/No

42. If yes, list them as:

_____

_____

_____

43. Those that you are ***unable*** to do: _____

44. Those that are ***painful*** to do: _____

45. Those that are ***difficult*** to do: _____

46. Please list your specific job requirements and how your accident is affecting your ability to perform them: _____

_____

_____

_____

47. Are you currently employed? Yes/No

48. Are you currently working? Yes/No

49. If so, are you currently able to perform your regular work duties? Yes/No

50. Is modified or alternate work available for you at your place of employment?

51. If yes, please explain: : _____

_____

_____

_____

52. Which best describes your job position: a) Sedentary/Limited
b) Light
c) Medium
d) Heavy
e) Very Heavy

_____ _____

(PATIENT SIGNATURE) (DATE)
