Primary Chiropractor Report

Date:	PIR:	☐Intake/Assessment Report ☐Progress Report

Customer Information	Practitioner Information
Claim Number:	SGI Payee Number:
Date of Accident:	First Name
First Name:	Last Name:
Last Name:	Clinic/Facility Name:
Date of Birth:	Address:
Gender:	City:
Health Card Number:	Province: Postal Code: Telephone Number:
Signature of Practitioner: _____	☐By checking this box, I verify this as my identity/ signature

Section 1: Past Medical History and Other Medical Conditions

Factors that may impede recovery:

☐Addictions		☐Psychosocial		☐Family
☐Dietary		☐General		☐Employment

☐Other:

Are there any pre-existing and/or concurrent health conditions (Describe):

Section 2: Current Assessment Findings

Date of Assessment:

Primary Diagnosis:

If spinal injury, please indicate injury level below:

☐Cervical	☐Thoracic	☐Lumbosacral

If spinal injury, indicate injury grade: (if> then one spinal area is involved, indicate with a C,T, or L beside the appropriate grade)

☐**Grade I:** symptoms, no signs Click or tap here to enter text.	☐**Grade II:** Symptoms and Musculoskeletal signs (ex. Decreased ROM, point tenderness) Click or tap here to enter text.
☐**Grade III:** symptoms and neurological signs Click or tap here to enter text.	☐**Grade IV:** symptoms and fracture/dislocation Click or tap here to enter text.

If peripheral joint, the diagnosis is:

Section 3: Presence of Permanent Scarring or Disfigurement ☐

Section 4: Summary of Subjective and Objective Findings (ROM, motor power, neurologic, etc.)

NOTE: **If Progress Report,** summarize and provide specific details and measures of CHANGES since the last report and include other findings since the initial assessment

Section 5: Client Reported Current Function

☐Full function without symptoms			☐Full function with symptoms	
Work:	☐Full	☐Modified Duties	☐Unable to Work	
Home and Yard ADL's:	☐Full	☐Assistance Required	☐Dependent	☐Non-Worker
Self-Care:	☐Full	☐Assistance Required	☐Dependent	
Less than full function (Explain):				

Section 6: Outcome Measure Used (MUST provide a minimum of one measure)

☐Roland Morris	☐QD Work Module	☐NDI	☐LEFS	☐VAS
☐Oswestry	☐COVS	☐TUG	☐Other:	

Section 7: Practitioner Reported Current Function

☐Work Full Duties	☐Work Modified Duties	☐Unable to Work	☐Non-Worker
Note any restriction on work duties:			
Note any restrictions on home, yard, ADL's and self care:			

Section 8: Treatment

1. *Identify the goal(s) in relation to the client's impairment(s), symptoms, or pathology that the management plan seeks to achieve:*

☐Pain Reduction	☐Increase in ROM	☐Increase in Strength	☐Biomechanical Restoration
☐Other (Specify):			

2. *Select the functional goal(s) that the management plan seeks to achieve:*

☐Return to activities of normal living	☐N/A- Expected return to activities date:
	☐N/A - Expected return to homemaking date:
☐Return to pre-accident work activities	☐N/A - Expected return to work date:
☐Return to modified work activities	☐N/A – Expected return to modified work activities date:
☐Other (Specify):	

Section 9: Management Plan (include duration and frequency of treatment)			
☐No Treatment	☐Multi-disciplinary	☐Specialist	☐Investigation (X-ray or Other)
Initial management plan (describe below):		Updated management plan (describe below):	
List the education provided and self-management strategies *(ex. HEP, Etc…)* to be implemented by the customer:			
1. Treatment Plan:			
☐Physical Therapist	☐Massage	☐Education	☐Electrophysical
☐Transitional RTW	☐Supervised Global	☐Regional Conditioning	☐Home ☐Supervised
☐Chiropractor	☐Other:		
2. Frequency of Treatment:			
3. Total Number of Treatments:			
4. Expected Number of Weeks to Discharge:			
Has the employer been contacted: ☐Yes		Has a RTW plan been arranged: ☐Yes ☐No	

Section 10: Compliance and Attendance

Section 11: Remarks

OFFICE USE ONLY	Section 6&8 Completed ☐YES ☐NO	**AUTHORIZATION FOR PAYMENT (sign and date)** _____

Report will only be paid if Outcome Measure Scores are included in the report

CC to: