

Patient Information

First Name		Last Name	
<input type="text"/>		<input type="text"/>	
DOB (mm/dd/yyyy)	Phone #	Gender	
<input type="text"/>	<input type="text"/>	<input type="text"/>	
Home Address		Postal code	
<input type="text"/>		<input type="text"/>	

Diagnosis/Clinical Impression:

Recommended Duration of Chiropractic Care:

of visits: (Max 10) Estimated timeline:

Recommended Plan of Management:

- Education/self-management
- Manual Therapy
- Modalities
- Referral
- Other

Notes:

Home Advice:

Coping strategies:	<input type="text"/>
Pain Relief:	<input type="text"/>
Exercise:	<input type="text"/>

Additional Comments:

1. Please indicate **abilities** that apply.

Walking:

- Full abilities
- Up to 100 metres
- 100 - 200 metres
- Other (please specify)

Standing:

- Full abilities
- Up to 15 minutes
- 15 - 30 minutes
- Other (please specify)

Sitting:

- Full abilities
- Up to 30 minutes
- 30 minutes - 1 hour
- Other (please specify)

Lifting from floor to waist

- Full abilities
- Up to 5 kilograms
- 5 - 10 kilograms
- Other (please specify)

Lifting from waist to shoulder:

- Full abilities
- Up to 5 kilograms
- 5 - 10 kilograms
- Other (please specify)

Stair climbing:

- Full abilities
- Up to 5 steps
- 5 - 10 steps
- Other (please specify)

Ladder climbing:

- Full abilities
- 1 - 3 steps
- 4 - 6 steps
- Other (please specify)

Travel to work

Ability to use public transit

- yes
- no

Ability to drive a car

- yes
- no

2. Please indicate **restrictions** that apply.

- Bending/twisting repetitive movement of (please specify)

- Work at or above shoulder activity: (please specify)

- Limited use of hand(s):

- | | |
|-----------------------------------|--------------------------|
| Left | Right |
| <input type="checkbox"/> Gripping | <input type="checkbox"/> |
| <input type="checkbox"/> Pinching | <input type="checkbox"/> |
| <input type="checkbox"/> Other | <input type="checkbox"/> |

- Limited pushing/pulling with:

- Left arm
- Right arm
- Other

- Operating motorized equipment: (e.g. forklift)

- Consult required to determine impact of drugs or other medical conditions

- Exposure to vibration
- Whole body
- Hand/Arm

Additional comments on functional abilities and/or restrictions:

Employment/Training:

Current status

- Currently in training program
- Currently employed part-time
- Currently employed full-time
- Currently unemployed/not in training program

Comments:

Desired employment/training plan patient is interested in:

Anticipated barriers for desired employment/training plan (if any):

- Current pain
- Decreased range of motion
- Loss of strength
- Other (please specify)

Comments:

Plans to Overcome Barriers (if applicable):

- Chiropractic treatment
- Stretching
- Strengthening
- Strategies to deal with flare ups
- Other (please specify)

Comments:

Recommendations for suitable employment path or programs:

- Ready to pursue desired training plan while receiving care
- Ready to pursue desired employment plan while receiving care
- Desired employment/training plan should be ok once treatments are complete
- Desired employment/training plan not suitable based on physical assessment, will be re-evaluated at end of plan of management
- Current plan not suitable based on existing injuries, alternative career planning recommended

Comments:

Recommended Resources

CCGI Exercise Videos

<https://www.chiropractic.ca/guidelines-best-practice/exercise-videos>

Take Charge Chronic Pain Workshop

<https://www.wselfmanagement.ca/Individual-Take-Charge-Chronic-Pain.htm>