

Part 1. Claimant Information

Last Name		First Name		Middle Name(s)
Mailing Address				City or Town
Province	Country	Postal Code	Email Address	
Telephone Number	Date of Birth (dd-mm-yyyy)		Date of Accident (dd-mm-yyyy)	
Employment Status (select all that apply)			Is the claimant off work or off studies? (if applicable)	
☐ Employed ☐ Not Employed ☐ Student ☐ Retired			☐ Yes ☐ No ☐ Modified duties/hours	
Policy Number (if known)		Claim Number (if known)		
Insurance Company				

Caregiving/Employment/Studies Status at the time of the accident (if applicable)

If involved in caregiving, are caregiving duties impacted by the injuries from this accident?		
☐ Yes	☐ No	☐ N/A
If employed and/or engaged in studies, select all that apply and provide job title where applicable. If off work, please complete Part 3		
Job title		

Part 2. Response to Treatment

Phase 1 Weeks 0-6

☐ Neck	Diagnosis	Response to Treatment
☐ Shoulder	Diagnosis	Response to Treatment
☐ Mid Back/Chest Wall	Diagnosis	Response to Treatment
☐ Low Back	Diagnosis	Response to Treatment
☐ Concussion	Diagnosis	Response to Treatment

Total number of treatment visits completed in Phase 1 	Planned number of treatment visits in Phase 2
---	---

Functional Limitations

Describe functional limitations and indicate impact on daily living assistance (DLA), caregiving duties, studies, work and/or other

Initial assessment (Date)	Phase 1 assessment (Date)	DLA	Caregiving	Studies	Work	Other
1.		☐	☐	☐	☐	☐
Initial assessment (Date)	Phase 1 assessment (Date)	DLA	Caregiving	Studies	Work	Other
2.		☐	☐	☐	☐	☐
Initial assessment (Date)	Phase 1 assessment (Date)	DLA	Caregiving	Studies	Work	Other
3.		☐	☐	☐	☐	☐

Claimant self-rated recovery response (Claimant perception of injury recovery)

	
----------------------	---

Part 3. Employment Activity (to be completed where applicable)

Fill this part if the claimant is currently off-work, on modified work duties, or is expected to be adjusting work status as a result of the injuries sustained from the accident

Functional limitation impacting employment	Relevant functional job demands	Treatment goal?
1.		☐ Yes ☐ No
Functional limitation impacting employment	Relevant functional job demands	Treatment goal?
2.		☐ Yes ☐ No
Functional limitation impacting employment	Relevant functional job demands	Treatment goal?
3.		☐ Yes ☐ No
Additional comments 		
☐ Can resume regular duties	On date (dd-mm-yyyy) 	Graduated hours, if required (enter duration)
☐ Can return to work with modified duties	On date (dd-mm-yyyy) 	Graduated hours, if required (enter duration)

Part 4. Barriers to Recovery

Barriers that may affect recovery (select all that apply)		
☐	Other (not in dropdown) _____	
☐	No barriers identified	
Barriers to attending treatment		If yes, specify
☐	Yes	☐ No

Part 5. Phase 2 treatment interventions based on Care Pathway(s) (to be completed where applicable)

Phase 2 Weeks 7-12

☐	Neck	Intervention(s) (select one or more)	
☐	Shoulder	Intervention(s) (select one or more)	
☐	Mid Back/Chest	Intervention(s) (select one or more)	
☐	Low Back	Intervention(s) (select one or more)	
☐	Concussion	Intervention(s) (select one or more)	
Describe the Phase 2 functional and recovery goals			
Expected Frequency of Clinic Treatment Visits Per Week Phase 2 (7-12 weeks)			
Additional treatment information			

Part 6. Health Outcome Measure at Phase 1

Health Outcome Measure			
WHODAS 2.0 (12-item)			
Date administered (dd-mm-yyyy)		Phase 1 Score	Score at Program of Care Initial Assessment
		/ 48	/ 48
Additional comments			
Professional License Number			

Part 7. Program of Care Health Care Practitioner Information

Full Name of Health Care Practitioner			
Profession			
☐ Chiropractor	☐ Nurse Practitioner	☐ Physician	☐ Physiotherapist
Professional License Number			
Mailing Address			
City	Province	Country	Postal Code
Clinic Name		Administrative Contact's Full Name	
Telephone Number		Fax Number	
Email		Preferred Contact Method	
		☐ Phone ☐ Email	

☐ I attest that I meet all the **requirements** to deliver the Care-First Program of Care, including education

Part 8. Program of Care Health Care Practitioner Signature

I certify that the information provided is true and correct to the best of my knowledge

Full Name of Program of Care Health Care Practitioner (Please Print)	Date Report Completed and Signed (DD/MM/YYYY)	Signature