

# DC Initial Visit Report

Patient ID: \_\_\_\_\_

Patient	Referring Clinic	Physician
_____	_____	_____
Age: _____ Sex: <input type="checkbox"/> Male <input type="checkbox"/> Female	From: _____	To: _____
_____	_____	_____
_____	_____	_____

**Presenting Complaint(s)** Please X appropriate box(es). Add additional information if required.

<b>Onset:</b> <input type="checkbox"/> Sudden <input type="checkbox"/> Insidious <input type="checkbox"/> Progressive	<input type="checkbox"/> MVA <input type="checkbox"/> WSIB <input type="checkbox"/> Trauma <input type="checkbox"/> Other	<b>Region:</b> <input type="checkbox"/> Head <input type="checkbox"/> Neck <input type="checkbox"/> Thoracic <input type="checkbox"/> Lumbar	<input type="checkbox"/> Pelvis <input type="checkbox"/> Extremity <input type="checkbox"/> Upper <input type="checkbox"/> Lower	<b>Pain:</b> <input type="checkbox"/> Constant <input type="checkbox"/> Intermittent <input type="checkbox"/> Sharp <input type="checkbox"/> Dull ache <input type="checkbox"/> Localized <input type="checkbox"/> Radiating	<b>Associated S/S</b> <input type="checkbox"/> Dizziness <input type="checkbox"/> Headaches <input type="checkbox"/> Weakness <input type="checkbox"/> Tingling
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**Medical History**

Significant Medical/Physical Illness: (list)

\_\_\_\_\_

**Examination** Please X appropriate box(es) if findings positive. Add additional information if required.

<b>Physical Examination</b> <input type="checkbox"/> Range of Motion <input type="checkbox"/> Muscle tightness/soreness	<input type="checkbox"/> Joint tenderness <input type="checkbox"/> Joint swelling	<b>Neurological Examination</b> <input type="checkbox"/> Reflex <input type="checkbox"/> Sensory <input type="checkbox"/> Motor
<b>Comment</b>	<b>Explain positive findings</b>	
_____	_____	

Red Flags (if present, see page 2)       Yellow Flags (psychosocial factors) (if present, see page 2)

**Diagnosis/clinical impression**

\_\_\_\_\_

**Recommended plan of management**

<input type="checkbox"/> Watchful waiting <input type="checkbox"/> Manual therapy <input type="checkbox"/> Soft tissue therapy <input type="checkbox"/> Other	<input type="checkbox"/> Exercise Program <input type="checkbox"/> Ergonomic advice <input type="checkbox"/> Education <input type="checkbox"/> Physical/adjunctive therapy	<input type="checkbox"/> Counselling <input type="checkbox"/> Functional restoration <input type="checkbox"/> Specialist Referral	<b>Treatment Frequency:</b> _____ <input type="checkbox"/> /week <input type="checkbox"/> /month	<b>Prognosis:</b> <input type="checkbox"/> Excellent <input type="checkbox"/> Favourable <input type="checkbox"/> Guarded	<b>Reassessment Period:</b> in _____ weeks
_____			<b>Treatment Duration:</b> for _____ weeks		

**Comments**

\_\_\_\_\_

**Signature:** \_\_\_\_\_ **Date** \_\_\_\_\_

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## Yellow Flags Symptoms

<input type="checkbox"/>	Belief that pain and activity are harmful
<input type="checkbox"/>	'Sickness behaviours' (like extended rest)
<input type="checkbox"/>	Low or negative moods, social withdrawal
<input type="checkbox"/>	Treatment beliefs do not fit best practice
<input type="checkbox"/>	Problems with claim and compensation
<input type="checkbox"/>	History of back pain, time-off, other claims
<input type="checkbox"/>	Problems at work, poor job satisfaction
<input type="checkbox"/>	Heavy work, unsociable hours (shift work)
<input type="checkbox"/>	Overprotective family or lack of support
<input type="checkbox"/>	Other:

## Red Flag Symptoms

<input type="checkbox"/>	Cauda Equina Syndrome
<input type="checkbox"/>	Severe Unremitting (non-mechanical) worsening pain
<input type="checkbox"/>	Significant trauma
<input type="checkbox"/>	Weight Loss, fever, history of cancer/HIV
<input type="checkbox"/>	Use of IV drugs or steroids
<input type="checkbox"/>	Patient over 50 (if first ever episode of serious back pain)
<input type="checkbox"/>	Widespread Neurological Signs
<input type="checkbox"/>	Other: