WYOMING WORKERS' COMPENSATION DIVISION

Chiropractic Patient Exam/Re-exam Form (Use if patient is under active care)

Return to: Workers' Compensation Division
1510 East Pershing Boulevard, South Wing
Cheyenne, Wyoming 82002
http://www.wyomingworkforce.org

Patient _____ Claim # _____ Date: _____
Has patient been discharged from care? Yes _____ If yes, please list date of discharge, sign and return form via fax to 307-777-6552
No _____ If no, please complete the form in its entirety _____Number of prior treatments

1) Current Subjective Complaints:

_____

_____

2) Activities of Daily Living Limitations or Duties Under Duress:

_____

_____

3) Exacerbations Since Last Exam:

_____

_____

4) Current Orthopedic / Neurologic Evaluation:

_____

_____

5) Measured Range of Motion: Cervical, Thoracic, Lumbar , Other _____ (circle)

	Normal	Current	Pain	Notes
Flexion				
Extension				
Right Lat Flex				
Left Lat Flex				
Right Rotation				
Left Rotation				

6) Muscle Strength Test:

_____

_____

7) P.D.Q. Scores:

_____

_____

8) Assessment :

_____

_____

9) Plan :

_____

_____

10) Additional Info. / Complicating Factors:

_____

_____

Doctor of Chiropractic Name: _____ Signature: _____