

Physical Therapy Re-Evaluation Components
Workers Compensation

1. WCB #:
2. Workers personal information
 - a. name
 - b. date of birth
 - c. employer name
 - d. employer address
 - e. adjusters name
 - f. adjusters phone #
 - g. wcb number
3. Referral source
 - a. MD
 - b. Chiropractor
 - c. Employer
 - d. Self-referral
 - e. PT consultant
 - f. Other
4. Date of accident
5. Date of referral
6. Date of Initial Assessment
7. Was the worker working at the time of initial assessment?
8. ICD-9 codes
9. Does the worker have a job to return to?
10. Has the worker had a similar problem previously?
11. Any surgery? If yes, is the treatment for pre or post surgery.
12. Is injury preventing worker from performing their customary work duties?
13. Any complicating factors affecting recovery?
14. Work capability at time of initial assessment.
 - a. very heavy
 - b. heavy
 - c. medium
 - d. light
 - e. sedentary
 - f. not capable
15. Job requirements/Treatment goals
 - a. very heavy
 - b. heavy
 - c. medium
 - d. light
 - e. sedentary
16. Were job requirements confirmed by
 - a. case worker
 - b. employer
 - c. both
 - d. none
17. Can modifications/alternate work be performed?
 - a. yes
 - b. no
 - c. not applicable
18. Work restrictions?
 - a. yes
 - b. no
 - c. if yes, permanent, temporary, unknown