Mission Statement for Whiplash Associated Disorders

The British Columbia Chiropractic Association (BCCA) is committed to delivering appropriate and cost-effective care towards maximal recovery for injured motorists who sustain whiplash-associated disorders (WAD). The British Columbia College of Chiropractors recommends the use of these guidelines by practitioners, insurers, and legal representatives.

General Disclaimer

The purpose of these guidelines is to assist in managing WAD and in measuring patient outcomes. In addition, guidelines might assist health insurance companies in managing claims and assessing patient outcomes. However, guidelines do not represent specific or individual case management recommendations, nor should they be considered standards of care. By scientific necessity, they are flexible and will change as new information provides better insight into the diagnosis and management of WAD.

Preamble

The “British Columbia Chiropractic Association Clinical Guidelines for the Management of Whiplash Associated Disorders” has been developed by the BCCA and is recommended by the BCCC for use by member practitioners.

Evidence-based care is the synthesis of clinical experience and judgement with the best scientific research (evidence) for a given condition (26). These guidelines seek to incorporate the principle of evidenced-based care, integrating the best scientific evidence with the collective BCCA clinical experience, in the development of outcomes management for WAD (4).

Introduction

The incidence of WAD in western societies varies widely depending on reporting structures. However, the magnitude of the problem is significant due to the prevalence of chronic symptoms for patients following a whiplash (1,6). The WAD related economic, health and social costs to society, the injured patient and to their families is considerable.

In British Columbia, over 35,000 people suffer each year from WAD due to motor vehicle crashes. The Insurance Corporation of British Columbia spends approximately 500 million dollars annually (31) to administer claims, replace income, litigate and lastly, pay for WAD treatment. This figure does not include the cost borne by other insurers including the Medical Services Plan of British Columbia, Workers Compensation Board or private insurers such as Pacific Blue Cross. Nor does it include the loss of productivity to employers or financial and emotional damage to families.

From the perspective of public safety, preventing whiplash-associated disorders through driver education, traffic safety measures and better vehicle design, is extremely important.

The BCCA Experience

The BCCA accepts the current best evidence in relation to the prevalence of chronic symptoms following a whiplash injury. Recent scientific reviews and research (6,7,17) indicate that the prevalence of chronic symptoms of WAD is not as optimistic as suggested by one publication, the Quebec Task Force (QTF) consensus on WAD(21). The QTF drew unsupported conclusions from the literature regarding the prevalence of chronic symptoms of WAD (29). In 1997 the BCCA published a Position Statement critiquing the QTF document (20). Today, the BCCA Position Statement is supported by a growing number of researchers (6,7,29). Presently, the best scientific estimates indicate that between 14 and 42% of patients will develop recurrent and intrusive episodes of pain, stiffness and loss of function following a whiplash injury (1,6,8,18,16,22). Approximately 10 percent of patients will develop chronic constant pain (9).
The BCCA whiplash experience is best summarized by Eni in a retrospective study of 805 patients managed by chiropractic doctors in British Columbia (4). The major findings are:

- Chiropractic intervention within 10 days of the accident achieved the highest rate of recovery when compared to chiropractic patients seen after a long delay from the date of injury.
- The average length of time from the date of injury to the initial chiropractic visit was 2.5 months.
- Increased delay for the initial chiropractic visit resulted in higher costs.
- A mean of 16 visits were required over an average of 5 months to achieve recovery (59%) or partial recovery (19%) in 78 percent of patients.

Chiropractic Scope of Practice

Chiropractic training emphasizes the diagnosis and management of patients with mechanical disorders of the spine and their related effects on the nervous system (3). Of importance is the compelling evidence that chronic neck pain and headache following a whiplash injury often arise from the cervical spine facet joints (zygapophyseal joints)(1,2,14,15). Chiropractic adjustments (manipulation) target mechanical dysfunction of zygapophyseal joints (13). Of significance, in the treatment of WAD, adjustment is considered a form of patient “activation” along with exercise and mobilization (21). Accordingly it is not surprising that chiropractic care achieves good results for many WAD sufferers including patients who do not respond to orthodox medical management (4,12,32).

Additional aspects of chiropractic intervention such as prescribing exercise, lifestyle counseling and occupational and ergonomic advice also aid in patient recovery (3). If indicated, additional diagnostic tests might be ordered such as radiographs or patients might also be referred to another health professional.

While spinal adjustments are a common chiropractic approach to treatment there are several other interventions that do not involve adjustments (3). Further, chiropractors use mobilization and other therapeutics such as electrotherapy and ultrasound and are thus able to manage and treat patients with non-spine related injuries as well.

Outcomes Management

The goals of WAD management include:

- Improving on the natural history of an injury
- Restoring patients to their normal or pre-accident activity levels
- Preventing recurrent or chronic symptoms

To attain these goals practitioners must skillfully guide both the patient’s injury(s) as well as the patient through the various phases of healing that might otherwise be incomplete. Here an important tool to assist the doctor is outcomes assessment and management.

Outcomes management for WAD is a patient-centred approach to making clinical decisions. It uses patient generated information, outcomes assessment, to enhance patient care towards a meaningful outcome, to the patient (10). Following a history, examination, diagnosis (Appendix F) and WAD grading (Appendix A-1), outcomes assessment provides the doctor with a starting point, a measurement of the impact of the injury on the patient’s functional status. The chiropractor, in partnership with the patient, is then able to develop a management/care strategy that involves treatment planning and collecting information (outcomes assessment) on the patient’s progress in functional status. Outcomes assessment measures whether anticipated improvement is occurring and if treatment objectives are being met. Insufficient improvement on repeat assessments will alert the doctor to review or change the management strategy. In addition, outcome assessment will help to establish if maximum therapeutic benefit has been attained (Management Algorithm-Appendix A-2).

The following outcomes assessment instruments have been found to be valid, reliable and responsive to changes in pain intensity or functional status of patients with whiplash or low back pain (24,25,29, 32). These include the Visual Analogue Scale (VAS) for the measurement of pain and the Neck Disability Index (NDI) and the Roland Morris Questionnaire (RMQ) for the measurement of function (Appendices C, D and E). A test is valid if it accurately measures what it is intended to measure. A reliable test consistently measures a condition. Lastly, a test is responsive if with repeated use it can measure change, over time (10). The VAS and these “condition-specific” measurement tools give meaningful information for WAD management and are therefore recommended by the BCCA for use in the management of WAD.
The BCCA recommends that outcome assessments be performed on initial visit and thereafter every three weeks unless, subject to improvement or a trial of care withdrawal, the patient is being followed less often. Assessments might also be obtained when a patient experiences an acute ‘flare-up’. To objectively measure changes in score patients should not be advised of their previous scores or be aware of how each instrument is scored. If after two consecutive assessments (six weeks) a minimal clinically important difference is not attained then other care options, referral or discharge should be considered (see Appendices C, D and E). For the purposes of these guidelines the minimal clinically important difference (MCID) may be defined “as the smallest change that is important to patients” (28).

A pain drawing (Appendix B) is also recommended by the BCCA. Although the pain drawing is not an outcome measure it pictorially captures the patient’s verbal pain description and records it in the file (33).

**Treatment Plan**

An important step in achieving successful patient outcomes and improving upon the natural history is to develop an individualized treatment plan that optimizes the patient’s healing requirements for each phase of the healing process. Tissue healing normally progresses through three phases, inflammatory, repair and remodeling. Treatment planning should recognize and support each phase of the patient’s healing process. The treatment plan sets objectives, helps determine the methods of achieving those objectives as well as estimates the time required. It follows naturally that in-office care will initially be more frequent to decrease inflammation, hasten repair and promote tissue remodeling. As the healing progresses, complete repair and remodeling require a transition to self-care and less frequent in-office care.

**Types of Care**

The BCCA recognizes three types of clinically necessary care in the management of WAD. These are therapeutic, supportive and palliative care.

1. Therapeutic care refers to care that improves the patient’s health status to the maximum therapeutic benefit or is necessary to re-establish the maximum therapeutic benefit following acute or intrusive episodes of symptoms and decreased function.

2. Supportive care is defined as care necessary to sustain maximum therapeutic benefit following a trial of care withdrawal in which a patient’s chronic symptoms and functional status significantly deteriorate. Supportive care is subsequent to patients complying with appropriate exercise regimens, lifestyle modifications and home-based self-care. This form of care is inappropriate if it leads to dependence on the practitioner, somatization, illness behaviour or secondary gain.

3. Palliative care relieves chronic symptoms and maintains improvement but does not increase the patient’s long term functional status and is provided on a ‘pre-requisite necessary’ basis. It is important to document the type of care needed and communicate this to the patient.

**Chiropractic Review Panel**

To help practitioners manage more complicated cases the BCCA has appointed a Chiropractic Review Panel. The purpose of the panel is to act as a resource for doctors to consult with on difficult cases especially for those who remain off work. Early intervention is extremely important to minimize the risk of chronic problems (see Appendix G). The BCCA therefore advises practitioners to obtain a patient file review by an independent Chiropractic Review Panel for patients who remain off work at three weeks post initial chiropractic consultation. After completing a file review the Panel will make recommendations on further patient management to the practitioner. In conjunction with the Panel’s recommendations, patients who remain off work at six weeks post initial chiropractic visit should be considered for a multi-disciplinary evaluation comprised of functional capacity, orthopedic and psychological tests as well as a workplace assessment. However, appropriate chiropractic care would continue during file review or other evaluations.

**Documenting Whiplash-Associated Disorders and Outcomes**

To further assist practitioners in documenting patients' injuries and clinical course two new report forms have been developed for use with these guidelines (Appendix H and I). These include a First Report and a Progress Report. The First Report (Appendix H-1) is a concise record of the patient’s motor vehicle accident history, examination findings, diagnoses and management plan. It is also designed to capture relevant information pertaining to the impact of the injury on the patient’s functional status and quality of life. In addition, the First Report will facilitate communication with insurers such as ICBC or the Chiropractic Review Panel.

The Chiropractor’s Progress Report (Appendix I-1) summarizes improvement in the patient’s pain, functional status and response to treatment. The “Complicating/Delayed Recovery Factors” section helps practitioners
review important factors for patients whose treatment objectives are not being met within a reasonably estimated time period.

Summary
The “Clinical Guidelines for the Management of Whiplash-Associated Disorders” serve as a practitioner tool to improve the patient management and outcomes for motorists who sustain a whiplash-associated disorder. They will evolve by necessity as newer research increases our understanding of the nature and treatment of these injuries.*

References
4. Eni, G. A retrospective examination of chiropractic treatment of whiplash injury in British Columbia. JCCA: Accepted for publication.

Suggested Reading

*Next revision November 2003.*
Appendix

A. Grading WAD and Management Algorithm

The grading of whiplash-associated disorders is adopted from the QTF consensus document (Appendix A-1) (27). However, as our understanding of WAD improves the grading system might also be redefined.

Algorithms are a convenient way to illustrate and understand patient management and clinical decision making (Appendix A-2). The “Algorithm for the Management of WAD” encompasses the outcomes management pathways discussed in these guidelines.

B. Pain Drawing

The pain drawing is self-administered and consists of a front and back outline of a body (Appendix B-1). Patients are asked to depict the extent and distribution of their symptoms on the drawing using various symbols to indicate ache and pain, pins and needles as well as numbness. Research indicates that it is not a useful tool in measuring patients’ psychological distress and inferences in this regard should be avoided (19).

C. Visual Analogue Scale (VAS)

The Visual Analogue Scale (Appendix C-1) is a one hundred millimeter line with “anchors” at both ends. The left anchor states “no pain at all” and the right anchor states “pain as bad as it could be”. Patients are asked to draw a perpendicular mark (not an X or an O) along the line corresponding to their present level of pain. It is quick and easy to administer and scoring is from the left anchor and measured in millimeters. The percentage of improvement is the difference between the initial and subsequent(s) measures divided by the initial measure and multiplied by 100.

Example:

Initial VAS

(No pain at all) 0 _________________________________________________________________________________________ 10 (Pain as bad as it could be)

Subsequent VAS

(No pain at all) 0 _________________________________________________________________________________________ 10 (Pain as bad as it could be)

Initial – Subsequent (mm) X 100 = Percentage Change

Initial (mm)

62mm-40mm X 100 = 28%

The main purpose of the VAS is to document improvement in the patient’s pain. Presently, there is no minimal clinically important difference (MCID) for the VAS. It therefore is the patient’s judgement whether or not an important difference has occurred. Caution must be emphasized against over-interpreting any improvement. For example, a patient whose original score is 20mm, and subsequent score is 10mm, has technically improved by 50%. However, is this meaningful to the patient?

D. Neck Disability Index (NDI)

The Neck Disability Index (Appendix D-1) consists of ten sections. A point value from 0 to 5 is scored for each of the 10 sections. Therefore, the maximum total score is 50. If all 10 sections are completed then the percentage disability is obtained by simply doubling the score. If the patient omits a section then the patient’s score is divided by the number of sections scored and multiplied by 5. This figure is subsequently multiplied by 100 to arrive at a percentage disability.

The minimal clinically important difference (MCID) for the NDI has not yet been studied. For the present, the MCID for the NDI is 10 percent.
Example

Section 2-Personal Care (Washing, Dressing, etc.)

<table>
<thead>
<tr>
<th>Point Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>A. I can look after myself normally without experiencing extra pain. 0</td>
</tr>
<tr>
<td>B. I can look after myself normally but it causes extra pain. 1</td>
</tr>
<tr>
<td>C. It is painful to look after myself and I am slow and careful. 2</td>
</tr>
<tr>
<td>D. I need some help but manage most of my personal care. 3</td>
</tr>
<tr>
<td>E. I need help every day in most aspects of self-care. 4</td>
</tr>
<tr>
<td>F. I do not get dressed; I wash with difficulty and stay in bed. 5</td>
</tr>
</tbody>
</table>

\[
\text{Patient's Score} \times 100 = \text{Percentage Disability}
\]

Number of Sections Completed x 5

Score Interpretation*

<table>
<thead>
<tr>
<th>Score</th>
<th>Disability</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>0%-20%</td>
<td>Minimal Disability</td>
<td>The patient can cope with most activities of daily living.</td>
</tr>
<tr>
<td>20%-40%</td>
<td>Moderate Disability</td>
<td>The patient experiences more pain and difficulty with activities of daily living as well as work.</td>
</tr>
<tr>
<td>40%-60%</td>
<td>Severe Disability</td>
<td>The patient’s pain interferes with work, personal care, social life and sleep.</td>
</tr>
<tr>
<td>60%-80%</td>
<td>Crippled</td>
<td>Patient’s pain interferes with all aspects of the patient’s life.</td>
</tr>
<tr>
<td>80%-100%</td>
<td></td>
<td>The patient is either bed-bound or exaggerating their symptoms.</td>
</tr>
</tbody>
</table>

*Adapted from Fairbank et al (5).

E. Roland Morris Questionnaire (RMQ)

The RMQ is a 24-item questionnaire (Appendix E-1) derived from the Sickness Index Profile (136 items)(24). The evidence suggests that the RMQ is more sensitive to change in sub-acute low back pain patients than the Oswestry Low Back Pain Disability Questionnaire and is therefore more appropriate for a chiropractic patient population (11). Patients are asked to mark only the sentences that describe their activities on that day. The sum of the marked items equals the score with a maximum score of 24.

A MCID has been studied for the RMQ (28). In relation to subsequent assessments the initial RMQ score must be taken into account (23). Improvement of 4 points or more for patients who initially score 9 to 24 on the RMQ is considered a minimal clinically important difference. The MCID for patients who score 8 or less on initial visit is 1-2 points (28).

F. Chiropractic History and Physical Examination

The Chiropractic History and Physical Examination ‘forms’ (Appendix F-1) are included in these guidelines only as a reference for practitioners. It is recognized that examination tests are determined by the patient’s history. The minimum requirements for examining and grading a cervical or lumbar spine disorder is spinal range of motion, neurological examination (sensory, motor and reflexes) as well as palpation findings.

G. Factors Potentially Associated with Chronic Pain

This information is included as reference material (Appendix G-1) to assist the doctor in completing the Chiropractor’s Progress Report (Complicating/Delayed Recovery Factors).

H. Motor Vehicle Accident-First Report

The BCCA strongly recommends the use of this form for all patients sustaining injuries related to motor vehicle accidents.

I. Motor Vehicle Accident-Progress Report

The BCCA recommends completing this report every three months or when a significant change in managing the patient is necessary such as at maximum therapeutic benefit or discharge.
## A-1 Grading Whiplash-Associated Disorders*

<table>
<thead>
<tr>
<th>Clinical Presentation</th>
<th>Grade**</th>
</tr>
</thead>
<tbody>
<tr>
<td>No complaint about the neck</td>
<td>0</td>
</tr>
<tr>
<td>Neck complaint of pain, stiffness, or tenderness</td>
<td>I</td>
</tr>
<tr>
<td>Neck complaint <strong>and</strong> musculoskeletal sign(s) which include decreased range of motion and tenderness</td>
<td>II</td>
</tr>
<tr>
<td>Neck complaint <strong>and</strong> neurological sign(s) which include decreased or absent deep tendon reflexes, weakness and sensory deficits</td>
<td>III</td>
</tr>
<tr>
<td>Neck complaint <strong>and</strong> fracture or dislocation</td>
<td>IV</td>
</tr>
</tbody>
</table>

*Adapted from Spitzer et al (27).

**Symptoms and disorders such as deafness, dizziness, tinnitus, headache, memory loss, dysphagia, and temporomandibular joint pain may be present in any grade.
B-1

Patient Name: [ ]

Date: [ ]

Use letters below to indicate type and location of discomfort

A = ACHE
B = BURNING
C = STABBING
N = NUMBING
P = PINNED & NEEDLES
O = OTHER
A-2 ALGORITHM FOR THE MANAGEMENT OF WAD

Grade I-III WAD

Treatment

Chiropractor’s First Report

Outcomes Assessment
Every Three Weeks

Grade IV WAD

Refer

5 DAYS

Off Work?
Yes

1 DAYS

Off Work?
Yes

2 DAYS

Chiropractor’s Progress Report

No

0 DAYS

Maximum Therapeutic Benefit?
Yes

Supportive or Palliative Care, Refer or Discharge

Continue Therapeutic Care

Chiropractor’s Progress Report

Yes

Multidisciplinary Evaluation

Recommendations

Chiropractic Review Panel
C-1 Visual Analogue Scale

Patient's Name: ____________________________ Date: ____________________________

Please place a mark through the line below that most accurately represents the pain you are experiencing at this moment. Please note the expressions at either end of the line.

(No pain at all) 0 ____________________________ 10 (Pain as bad as it could be)
I cannot lift or carry anything at all.
I can lift only very light weights.
Pain prevents me from lifting heavy weights, but I can lift heavy weights without causing extra pain.
I can look after myself normally without causing extra pain.
It is painful to look after myself, and I am slow and careful.
I need some help but manage most of my personal care.
I can look after myself normally without causing extra pain.
I can look after myself normally, but it causes extra pain.
I need help every day in most aspects of self-care.
I do not get dressed. I wash with difficulty and lay in bed.

I can read as much as I want with no neck pain.
I can read as much as I want because of moderate neck pain.
I can't read as much as I want because of severe neck pain.
I can't read at all.

I have no headaches at all.
I have slight headaches that come infrequently.
I have moderate headaches that come infrequently.
I have severe headaches that come frequently.
I have moderate headaches that come frequently.
I have severe headaches that come frequently.
I have slight headaches that come infrequently.
I have no headaches at all.

Patient Name ______________________ Date ____________
5.1 Roland Morris Questionnaire

When your back hurts you may find it difficult to perform many activities throughout the day. Statements below have been used by people to describe those times when they are experiencing back pain. As you read through them, some may stand out because they describe your pain today. Therefore, please check the box that best describes your pain today. If the sentence does not fit, then just leave it blank and move on to the next one.

| q | I stay at home most of the time because of my back. |
| q | I change positions frequently to try to get my back comfortable. |
| q | I walk more slowly than usual because of my back. |
| q | Because of my back, I am not doing any of the jobs that I usually do around the house. |
| q | Because of my back, I use a handrail to walk upstairs. |
| q | Because of my back, I lie down to rest more often. |
| q | Because of my back, I have to hold on to something to get out of my chair. |
| q | Because of my back, I try to get other people to do things for me. |
| q | I get dressed more slowly than usual because of my back. |
| q | I only stand up for short periods of time because of my back. |
| q | Because of my back, I try not to bend or kneel down. |
| q | I find it difficult to get out of a chair because of my back. |
| q | My back is painful almost all the time. |
| q | I find it difficult to turn over in bed because of my back. |
| q | My appetite is not very good because of my back pain. |
| q | I have trouble putting on my socks or stockings because of my back. |
| q | I only walk short distances because of my back pain. |
| q | I don’t sleep well because of my back. |
| q | Because of my back pain, I get dressed with help from someone else. |
| q | I sit down for most of the day because of my back. |
| q | I avoid heavy jobs around the house because of my back. |
| q | Because of my back pain, I am more irritable and bad-tempered with people than usual. |
| q | Because of my back pain, I walk upstairs more slowly than usual. |
| q | I stay in bed most of the time because of my back. |

score ________  [24]
Chiropractic History and Physical Examination

A) History

Includes:
• history of present accident including mechanism of injury
• history of previous accidents or injuries
• history of previous neck – back conditions – length of time for recovery
• history of work loss due to previous neck – back conditions
• history of previous treatment
• general health medical history
• current complaints
• pain quality, quantity, radiation severity and timing
• aggravating and relieving factors
• effects on ability to work
• effects on activities of daily living
• medications

B) Examination

Includes:
• active range of motion
• passive range of motion
• reflexes
• sensation
• motor power
• palpation – vertebral – soft tissue

Might also include:
• resisted ranged of motion
• foramen compression tests
• facet joint compression tests
• vertebral artery tests
• brachial plexus stretch tests
• peripheral joints exam
• Waddell’s signs

C) X-rays

• A minimum study of cervical spine consists of an anterior-posterior, open mouth and lateral views. Oblique views may be required in cases of suspected neurological deficits. Flexion-extension views may be necessary for bio-mechanical instability, dislocation and fractures.

D) Diagnosis

• Must be consistent with mechanism of injury and history and examination findings.

E) Treatment Plan

• Includes identifying functional limitations, treatment objectives, methods of achieving objectives, re-examination times and overall estimated time to meet objectives. Should include a mix of passive and active modalities with patient self-management strategies and an emphasis on early return to work/usual activities.
G-1 Factors Potentially Associated with Chronic Pain

A) Yellow Flags (Psychosocial):

- presence of a belief that back pain is harmful or potentially disabling
- fear-avoidance behaviour and reduced activity levels
- tendency to low mood and withdrawal from social interaction
- an expectation that passive treatments rather than active participation will help
- job dissatisfaction
- multiple different providers previously for same condition

B) Red Flags:

- sedative/hypnotic use
- narcotic use
- multiple caregivers
- major affective disorders
- previous significant time loss work
Motor Vehicle Accident - First Report

Claim Number: ________________________________
Surname of Patient: ___________________________ Given Name: ___________________________
Address: ____________________________________________________________________________
Date of Birth (mm/dd/yy): _________________ Gender: ☐ Male ☐ Female
Occupation: ___________________________ Adjuster’s Name _______________________________
Date of Accident (mm/dd/yy): _______________ Date of this Examination (mm/dd/yy): ___________

Patient was seated: driver’s seat, passenger, right rear, left right, other __________________________

AS A RESULT OF THE ACCIDENT, THE PATIENT:

Sustained a loss of consciousness: ☐ Yes ☐ No
If Yes, duration and patient's description: __________________________________________________

Complains of neck pain? ☐ Yes ☐ No
Complains thoracic pain? ☐ Yes ☐ No
Complains of low back pain? ☐ Yes ☐ No
Complains of secondary symptoms? ☐ Yes ☐ No
Was a seat belt used? ☐ Yes ☐ No

Type: 3-point over shoulder ☐ Lap ☐ Other ☐
Did any part of their body make contact with the interior of the vehicle? ☐ Yes ☐ No
If Yes, describe contact: ___________________________________________________________________

Was the patient looking straight ahead at time of impact? ☐ Yes ☐ No
If No, describe position: ___________________________________________________________________

First care was given at: ☐ hospital ☐ this office ☐ other: ________________________________
Have any X-rays been taken? ☐ No ☐ Yes
If Yes, results: ________________________________________________________________________

Received any medication? ☐ Yes ☐ No If yes, list: __________________________________________
What was the patient's pre-accident health status? __________________________________________

Symptoms and other Injuries: __________________________________________________________________

Examination Findings (spinal ranges of motion, upper or lower extremities sensory, motor or reflex changes, positive orthopaedic tests and palpation findings: ____________________________
_________________________________________________________________________________________

Radiographic/Other Diagnostic Test Findings: __________________________________________________________________

_________________________________________________________________________________________

VAS Score: ____ NDI Score: ____ Oswestry Score: ____ RMQ Score: ____
Motor Vehicle Accident - First Report

WAD Classification: (Grade I, II, III or IV)

Current Pain Frequency Levels and Location:
Constant (76-100%): ___________________ Frequent (51-75%): ___________________
Occasional (26-50%): ___________________ Intermittent (25% or less): ___________________

Current Function
1) Full function without symptoms: ☐ Yes ☐ No
2) Full function with symptoms: ☐ Yes ☐ No
3) Less than full function due to symptoms and/or functional deficit: ☐ Yes ☐ No
4) Significant limitation in function: ☐ Yes ☐ No

Current Work Capacity
In my opinion, the patient is able to:
☐ Work full duties ☐ Work modified duties ☐ Unable to work at any job
If unable to return to work, state why and expected return or re-assessment date: ___________________

Management Plan (circle)
1) Maintain usual activities.
2) Limit usual activities. How long? ___________________
3) Treatment frequency per week and for how long? ___________________
4) Exercise - specify: ___________________
5) Prescribed splints/supports - specify: ___________________
6) Referral required? ☐ Yes ☐ No If yes, practitioner: ___________________
7) Anticipated duration of in-clinic care: ___________________
8) Re-examination date: ___________________

Patient Authorization
I hereby authorize the release of this report to the Insurance Corporation of British Columbia and legal representative in support of my claim.
Signature: ___________________ Date: ___________________

Chiropractor:
______________________________
Address: ________________________
Phone: ___________________ Fax: ________________________
Signature: ___________________ Date: ___________________
Motor Vehicle Accident - Progress Report

Date: ____________________________  Claim Number: ________________________

Patient's Name: ____________________________

Current Clinical Status: ____________________________

VAS Score: ______  NDI Score: ______  Oswestry Score: ______  RMQ Score: ______

Current Pain Frequency Levels and Location:

Constant (76-100%) ____________________________  Frequent (51-75%): ____________________________

Occasional (26-50%) ____________________________  Intermittent (25% or less): ____________________________

Symptoms: ____________________________________________________________

Examination Findings: ____________________________________________________________

Complicating / delayed recovery factors

1) Symptom flare-up: ____________________________________________________________
2) Second (new) injury: ____________________________________________________________
3) Prolonged static posture/activities, home/work: ____________________________________________
4) Significant delay in initiating chiropractic treatment. If so, why?: ____________________________
5) Pre-existing health condition(s): ____________________________________________________________

Recovery status Since last report this patient’s condition has:

☑ Improved  ☐ Not improved  ☐ Worsened

Patient outcomes (refer to BCCA/ICBC Guidelines page 2):

☑ Recovered to pre-injury status
☑ Patient requires further chiropractic care
☐ Has reached maximum recovery, with persistent symptoms that require supportive or palliative care; rehabilitation; or multidisciplinary evaluation. (Attach details).

Referral required ☐ Yes  ☐ No  If Yes, to practitioner: ____________________________

Current Management Plan

Future treatment required: ____________________________________________________________

Expected frequency and duration: ____________________________________________________________

Expected discharge date: ____________________________________________________________

Patient Authorization

I hereby authorize the release of this report to the Insurance Corporation of British Columbia and legal representative in support of my claim.

Signature: ____________________________  Date: ____________________________

Chiropractor: ____________________________  Date: ____________________________

Address: ____________________________  Phone: ____________________________  Fax: ____________________________