

INJURY CLAIM QUESTIONNAIRE

***All information is required in order to proceed with your WorkSafe BC claim**

*Name: _____ *Today's Date: _____
 *WorkSafe BC Adjudicator: _____ *Claim Number: _____
 *Date of Accident (mm/dd/yyyy): _____ *Time: _____ (a.m./p.m.)
 *Company Name: _____
 Contact: _____ *Work Phone: _____ Ext _____
 *Location of Accident: (Street) _____ *(Province) _____
 (City) _____ *(Postal Code) _____
 *Occupation: _____ *Carecard #: _____

Have you completed Form 8 for WorkSafe? Yes / No

Did you have surgery as a result of this accident? Yes / No

Did you have any complaints before the injury? Yes / No

Did you report your injury? Yes / No

Briefly explain how your injury happened: _____

Where did you feel pain? _____

AFTER the INJURY

As a result of the accident, you were: ☐ conscious & alert
☐ dazed, circumstances vague ☐ rendered unconscious (for how long? _____)
☐ other: _____

Please describe how you felt immediately after the accident: _____

Indicate the symptoms you are experiencing as a result of this accident (circle):

- | | | | |
|---|--|---|--|
| ☐ Dizziness | ☐ Difficulty sleeping | ☐ Jaw problems | ☐ Nausea |
| ☐ Memory loss | ☐ Irritability | ☐ Arms / shoulder pain | ☐ Back pain |
| ☐ Headache(s) | ☐ Fatigue | ☐ Numb hands/fingers | ☐ Lower back pain |
| ☐ Blurred vision | ☐ Tension | ☐ Chest pain | ☐ Back stiffness |
| ☐ Buzzing in ear | ☐ Ears ringing | ☐ Neck pain | ☐ Leg pain |
| ☐ Stomach upset | ☐ Shortness of breath | ☐ Neck stiff | ☐ Numb feet/toes |

Your condition: is getting worse / is getting better / is constant / comes & goes.

Have you seen or had treatment from any other health care provider? Yes / No

☐ If yes, whom? _____

Have you had any x-rays since the accident? Yes / No

Was medication prescribed? Yes / No If yes, what? _____

WORK ACTIVITIES

Did you miss any work immediately after this injury? Yes / No

Have you been able to work since this injury? Yes / No

Are your work activities restricted as a result of this injury? Yes / No
If so, how? _____

How many hours are in your normal workday? _____

Please indicate your normal daily job duties/activities (circle):

- | | | | |
|-----------------------------------|---|--|--|
| ☐ Standing | ☐ Sitting | ☐ Driving | ☐ Operating equipment |
| ☐ Walking | ☐ Lifting (how heavy? _____) | ☐ Work with arms above head | |
| ☐ Twisting | ☐ Crawling | ☐ Bending | ☐ Typing |
| ☐ Digging | ☐ Other: _____ | | |

While in recovery, is there any light duty work which you could request? Yes / No

Do you work with others who could help you with heavy lifting? Yes / No

Do any other diseases/conditions or accidents affect your employment? Yes / No
If yes, please explain. _____

Is there anything else you would like us to know? _____

I understand that I am ultimately responsible for all of my charges at this office. If this claim is **not** covered by WorkSafe BC, I authorize that the Visa/Mastercard number I have supplied will be charged for the treatments I have received.

If seeing a Chiropractor there will be a \$20 fee charged per office visit on areas other than the injured area accepted by this WorkSafeBC claim. I understand this fee is my responsibility and is not reimbursed by WorkSafeBC.

I declare these answers to be true to the best of my knowledge.

Signature

Date