WorkSafe BC

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? _____

Please Turn Over

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