WORKER'S COMPENSATION / ACCIDENT FORM

NAME

DATE (DD/MM/YY)

DATE OF INJURY

AREA OF WCB CLAIM # (IF ANY)

WCB CLAIMS PERSON

FAMILY PHYSICIAN

OCCUPATION

EMPLOYER'S NAME

EMPLOYER'S ADDRESS

CITY

POSTAL CODE

What type of work do you do? ______________________

Was the accident reported at work? ❍ Yes ❍ No

SUPERVISOR'S NAME

Describe the Accident:

1) Have you missed any work because of the injury? ❍ Yes ❍ No

IF YES, HOW MANY DAYS?

2) Have you sought any other medical attention for this injury? ❍ Yes ❍ No

IF YES, FROM WHOM?

Their diagnosis: ______________________ Medications: ______________________

3) Have you had previous X-Rays? ❍ Yes ❍ No

IF YES, WHERE?

4) Have you had any previous WCB claims? ❍ Yes ❍ No

WHEN & FOR WHAT CONDITION(S)?

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5) Have you had any previous injury in the same area? ❍ Yes ❍ No

IF YES, DESCRIBE

6) Do you have any diagnosed conditions of the spine, joints, muscles, or nervous system?

Please check any of the following symptoms you have experienced since the accident:

- ❍ Neck pain
- ❍ Neck stiffness
- ❍ Shoulder pain
- ❍ Headache
- ❍ Pain between the upper shoulders
- ❍ Upper extremity numbness &/or tingling
- ❍ Upper extremity weakness
- ❍ Mid back pain
- ❍ Low back pain
- ❍ Lower extremity numbness &/or tingling
- ❍ Lower extremity weakness
- ❍ Lower extremity pain
- ❍ Dizziness
- ❍ Hoarseness
- ❍ Jaw noise (clicking, popping, cracking)
- ❍ Jaw locking
- ❍ Squinting of the eyes
- ❍ Eyes tearing
- ❍ Flushing
- ❍ Salivation
- ❍ Runny nose
- ❍ Difficulty swallowing
- ❍ Decreased concentration
- ❍ Impaired logical thought
- ❍ Impaired memory
- ❍ Lightheadedness
- ❍ Sensitivity to light
- ❍ Hearing change
- ❍ Blurred vision
- ❍ Sensitivity to sound
- ❍ Facial pain
- ❍ Pulling sensation behind eyes
- ❍ Nausea
- ❍ Fatigue easily
- ❍ Mood changes
- ❍ Personality change
- ❍ Irritability
- ❍ Depression
- ❍ Loss of libido
- ❍ Insomnia

7) Do you have any previous history of the above symptoms prior to this accident? ❍ Yes ❍ No

IF YES, DESCRIBE

8) Do you have any additional information that you would like to inform us of?

Release Statement

I understand that my case is subject to review and possible rejection by the Worker's Compensation Board and that this office will prepare any necessary reports and forms that will assist me in securing my claim from WCB. I further understand that should my claim be rejected by WCB, I will be responsible for all services and charges rendered to me.

PATIENT SIGNATURE