WORKERS COMPENSATION / ACCIDENT FORM

NAME | AGE | DATE OF BIRTH (MM/DD/YY) | GENDER

DATE OF INJURY | AREA OF WCB CLAIM # (IF ANY) | HEALTH CARD NO.

WCB CLAIMS PERSON (IF KNOWN) | FAMILY PHYSICIAN

OCCUPATION | EMPLOYER'S NAME

EMPLOYER'S ADDRESS | CITY | POSTAL CODE | PHONE NUMBER

What type of work do you do? _____

Was this accident reported at work ❍ Yes ❍ No

SUPERVISOR'S NAME

Describe the accident: _____

Have you missed any work due to the injury?
❍ Yes ❍ No If yes, how many days? _____

Have you sought any other medical attention for this injury?
❍ Yes ❍ No If yes, from whom? _____
Their diagnosis: _____
Medications: _____

Have you had previous x-rays?
❍ Yes ❍ No If yes, from where? _____

Have you had any previous WCB claims?
❍ Yes ❍ No When? _____
For what condition? _____

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Have you had any previous injuries to the same area?
❍ Yes ❍ No If yes, please describe: _____

Do you have any diagnosed conditions of the spine, joints, muscles, or nervous system: _____

_____

_____

Diseases history: (PLEASE CHECK ALL APPLICABLE)

- ❍ 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
- ❍ Sound Sensitivity
- ❍ Facial Pain
- ❍ Pulling sensation behind eyes
- ❍ Nausea
- ❍ Fatigue easily
- ❍ Mood changes
- ❍ Personality change
- ❍ Irritability
- ❍ Depression
- ❍ Loss of libido
- ❍ Insomnia

Do you have any previous history of the above symptoms prior to this accident?
❍ Yes ❍ No If yes, please describe: _____

_____

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 thay 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 DATE

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