Workers' Compensation Board
Alberta

P.O. BOX 2415,
EDMONTON, ALBERTA
T5J 2S5
**Fax: (780) 427-5863,
1-800-661-1993**

WORKER'S PROGRESSIVE INJURY QUESTIONNAIRE

Claim Number

Will you be off work due to this injury? ☐ Yes ☐ No

Personal Health Number

Worker's Name *(Surname)* *(First Name)* *(Initial)*

Date of Birth *(Year / Month / Day)*

To help us decide if your progressive injury is work related, we require answers to the following questions:

What is your job title? ______

Describe your typical work day.

______

______

______

How long has this been your typical work day? ______

Describe any changes to your work day which you feel could have caused or increased your symptom(s)? ______

______

______

Symptom(s)? *(Please check appropriate box{es})*

☐ Aching ☐ Weakness ☐ Burning
☐ Tingling ☐ Stiffness ☐ Other ______
☐ Numbness ☐ Pain

When were the symptom(s) first noticed? ______

Location of symptom(s). *(Please check appropriate box{es})*

	Right	Left		Right	Left		Right	Left
Hand	☐	☐	Wrist	☐	☐	Neck	☐	☐
Shoulder	☐	☐	Elbow	☐	☐	Forearm	☐	☐
Fingers	☐	☐	Upper Back	☐	☐	Lower back	☐	☐

Other ______

Are you right or left hand dominant? ☐ Right ☐ Left

Tasks you perform in your job:

	Perform these tasks		Continuous?		How long do you perform the task each time?	How many times per day do you do the task?
	Yes	No	Yes	No		
Keyboarding	☐	☐	☐	☐	______	______
Mouse Usage	☐	☐	☐	☐	______	______
Mail Sorting	☐	☐	☐	☐	______	______
Cashiering	☐	☐	☐	☐	______	______
Lifting	☐	☐	☐	☐	______	______
Carrying	☐	☐	☐	☐	______	______
Pushing	☐	☐	☐	☐	______	______
Pulling	☐	☐	☐	☐	______	______
Other ______	☐	☐	☐	☐	______	______

Worker's Name *(Surname)*	*(First Name)*	*(Initial)*	Claim Number

Which of the work tasks cause or increase your symptom(s)? ______

Does the movement involve?

☐ Twisting motion ☐ Wringing motion ☐ Above shoulder level work ☐ Gripping motion

List tools/equipment used with the above motion: ______

Do you take scheduled breaks? ______

How long? ______ minutes How often? ______ minutes

List medical treatment obtained for this condition: *(including tests, x-rays, etc.)*

Doctor's Name	Address	Date of Treatment	Kind of Treatment

Do you suffer from any of the following medical conditions?

Diabetes	☐ Yes	☐ No
Heart Condition	☐ Yes	☐ No
Hypo/Hyper-Thyroidism	☐ Yes	☐ No
Other ______	☐ Yes	☐ No

List all medications you are currently taking: ______

Have you ever had other injuries to the same body site? If yes, explain. *(Including claims with other Boards)* ______

List any hobbies, sporting, volunteer or recreational activities that you are involved in. ______

Is there any activity you can no longer do as a result of your injury? If yes, explain. ______

Do you have any other information about your injury? ______

Date: ______ Name (please print): ______ Signature: ______

If we need to obtain further information when is the best time for us to reach you? ______

In order that this claim can be handled as quickly as possible, please return this information by either:

- **Fax** **427-5863 or 1-800-661-1993** **If you fax the report, do not send another by mail.**

or

- **Mail to: WCB, PO Box 2415, Edmonton, AB T5J 2S5**

Any questions? Edmonton: 498-3800, Calgary: 517-6000, Toll Free: 310-0000 (ask operator for 498-3800)