

WCB History of Injury Form

Welcome to Family First Chiropractic

Name _____
Address _____
City _____ Prov _____ PC _____
Phone: (H) _____ (W) _____
E-mail _____
Date of Birth _____ (Age _____)
Height: _____ Weight: _____

WCB Claim Number: _____
Case Manager _____ Phone # _____
Employers name _____
Employers address _____
City _____ Prov _____ PC _____

Date and time of injury _____

Any witnesses? Y N If yes please name _____

Other Doctors seen for this condition? Y N If yes please name _____

At time of accident where did you feel pain?

Onset of symptoms: (Sudden/gradual/other)

Any other symptoms/complaints?

Since injury are symptoms: Improving worsening the same comes and goes constant
other _____

Explain in detail how the accident happened. (Please note if you were lifting, bending, twisting, pushing, pulling, did you fall/trip (right, left, front, back,), something hit you, weight of object(s) etc...)

Have you ever injured this area before? Y N If yes when and how?

Who did you report this injury to? (supervisor, company...)

Before the injury, were you able to work on an equal basis with others your age? Y N
If yes, when was the last day of work? _____ estimated date of return? _____

Are your activities restricted as a result of the injury? Y N If yes, please explain.

I hereby certify that all of the information stated above is complete and accurate to the best of my knowledge.

Signature

Date