wcb Workers' Compensation Board – Alberta
P.O. BOX 2415
EDMONTON AB T5J 2S5
Fax: (780) 427-5863
1-800-661-1993

C504
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)*

Address: *Street* *City/Town* *Province*

Postal Code:

Telephone Number:

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? _____ Telephone Number: _ _ _ _ _ _ _ _ _ _

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

Fax 780-427-5863 or 1-800-661-1993 If you fax the report, do not send another by mail.

or Mail to: PO Box 2415, Edmonton AB T5J 2S5

Any questions? Edmonton: 780-498-3999, Calgary: 403-517-6000,
Toll Free: anywhere in Alberta 1-866-922-9221 and then dial the office nearest you.