

		Claim Number	
		Personal Health Number	
Will you be off work due to this injury? <input type="checkbox"/> Yes <input type="checkbox"/> No		Date of Birth (Year / Month / Day)	
Worker's Name (Surname)	(First Name)	(Initial)	
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))

<input type="checkbox"/> Aching	<input type="checkbox"/> Weakness	<input type="checkbox"/> Burning
<input type="checkbox"/> Tingling	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Other _____
<input type="checkbox"/> Numbness	<input type="checkbox"/> Pain	

When were the symptom(s) first noticed?  
\_\_\_\_\_

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

	Right	Left		Right	Left		Right	Left
Hand	<input type="checkbox"/>	<input type="checkbox"/>	Wrist	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Forearm	<input type="checkbox"/>	<input type="checkbox"/>
Fingers	<input type="checkbox"/>	<input type="checkbox"/>	Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	Lower back	<input type="checkbox"/>	<input type="checkbox"/>
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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mouse Usage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mail Sorting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cashiering	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

Worker's Name (Surname)	(First Name)	(Initial)	Claim Number
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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	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart Condition	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hypo/Hyper-Thyroidism	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Other _____	<input type="checkbox"/> Yes	<input type="checkbox"/> 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.**