

# WORKER'S PROGRESSIVE INJURY QUESTIONNAIRE

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

- |                                   |                                    |                                      |
|-----------------------------------|------------------------------------|--------------------------------------|
| <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? \_\_\_\_\_

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

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