CHIROPRACTIC ASSOCIATES CLINIC

W.C.B. ACCIDENT REPORT CLAIM FORM

Patient's Name: _____ Date: __ __ / __ __ / __ __
M M D D Y Y

Date of accident: __ __ / __ __ / __ __ Time of accident: __ __ : __ __ AM / PM
M M D D Y Y

WCB Claim _____ Were WCB forms filled out by your employer? ☐ Yes ☐ No

Adjuster: _____ Adjuster's Phone Number: (_ _ _) _ _ _ - _ _ _ _

Name of employer: _____ Employer Phone: (_ _ _) _ _ _ - _ _ _ _

Employer Address: _____

Location where you were when the accident occurred? _____

What were the circumstances leading up to the accident? _____

_____

Describe the injury. _____

_____

Were there witnesses? ☐ Yes ☐ No

If yes, who? _____

What did you do immediately after the accident? _____

Have you ever had a WCB claim before? ☐ Yes ☐ No

If yes, what was the injury? Was it for a similar complaint? _____

_____

Have you lost any time at work since this accident? ☐ Yes ☐ No

If so, what dates have you missed? _____

Have you seen another health care provider in regards to this accident? ☐ Yes ☐ No

If yes, who did you see and what treatment/advice was given? _____

_____

Is there a previous condition that might have a bearing on this injury? ☐ Yes ☐ No

If yes, please describe: _____

Are you able to work at your full capacity now? ☐ Yes ☐ No

If not, what limitations are you experiencing? _____

_____

Are you able to all of your activities of daily living? ☐ Yes ☐ No

If not, what limitations are you experiencing? _____

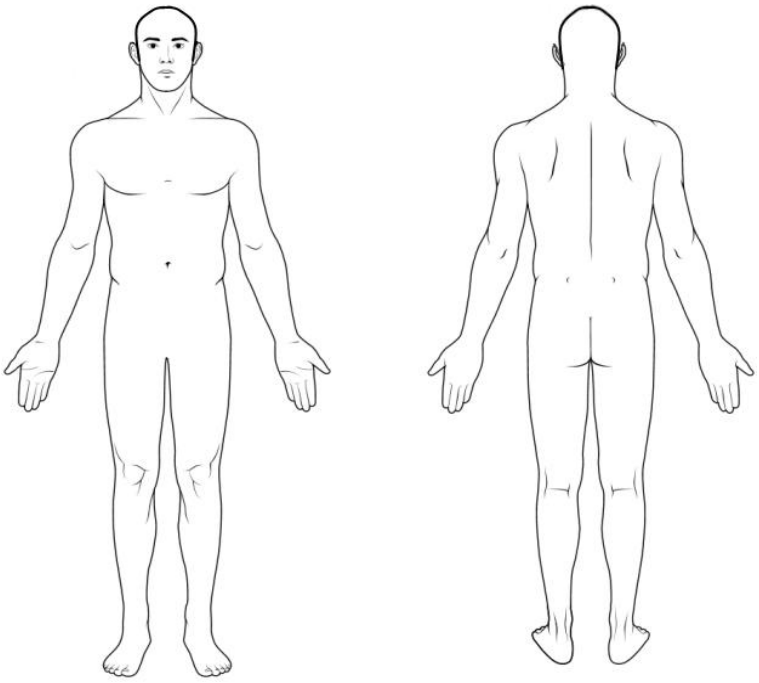
_____

PAIN QUESTIONNAIRES

Body Pain Diagram

Please fill this out carefully. Use the appropriate symbols (provided below) to mark the area on the diagram where you feel the described sensation. Include all affected areas, including radiation of pain.

Numbness	= = =
Burning Pain	x x x
Aching Pain	(((
Pins & Needles	o o o
Stabbing Pain	/ / /



Visual Analog Scale

If you had to rate your pain on a scale of 0 - 10, (0 = no pain, 10 = most pain imaginable), where would you rate your pain right now? Please indicate on this scale with a check or circle.

0 1 2 3 4 5 6 7 8 9 10

Date

Signature