

SPECIFIC PATIENT INFORMATION FOR WCB CLAIM

WCB Claim Number: _____
Date of Injury (Y/M/D): / / Time: _____ am/pm Time lost off work? YES/NO
Address Where You Were Injured: _____
Have you filled out an Incident Report with your Employer YES/NO

Has this injury been reported to WCB? YES/NO Are you in contact with your case worker? YES/NO
If no, please fill out Workers Report of Injury C060 before continuing

Worker's Information

Surname:	Given Names:	DOB (Y/M/D) / /
Address:		Postal Code:
Alberta Healthcare Number:	Telephone Number:	

Employment Information

Company Name:		
Address:		Postal Code:
Position/Title:	Supervisor/ Case Worker:	Telephone Number:
Job Description:		
Which best describes your pre-injury job requirements? <input type="checkbox"/> Sedentary/Limited <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very heavy		
Which best describes your post-injury job requirements? <input type="checkbox"/> Sedentary/Limited <input type="checkbox"/> Light <input type="checkbox"/> Medium <input type="checkbox"/> Heavy <input type="checkbox"/> Very heavy		
Are you currently working? YES/NO If so, are you currently able to perform your regular work duties? YES/NO		

Is modified or alternate work available for you at your place of employment? **YES/NO**
If yes, please explain:

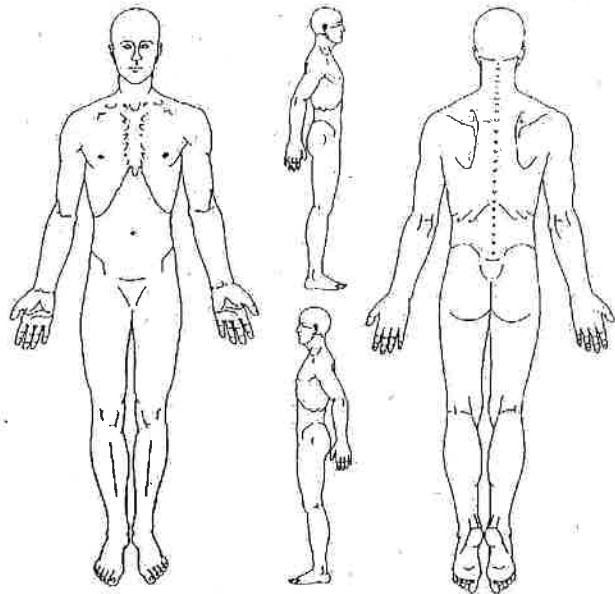
Please list any specific job requirements and how your accident is affecting your ability to perform them:

Injury Information

Describe what happened to you at the time of your injury (how and where):

Have you been unable to work or missed time from work due to injury? **YES/NO**
If yes please list dates and times below

Describe your complaint (site and symptoms including cuts/bruises):



USE THE LETTERS BELOW TO INDICATE THE TYPE AND LOCATIONS OF YOUR SENSATIONS RIGHT NOW
KEY: A = ACHE B = BURNING N = NUMBNESS P = PINS & NEEDLES S = STABBING O = OTHER

Please check if you are experiencing any of the following symptoms:

- | | | |
|--|--|--|
| <input type="checkbox"/> headache | <input type="checkbox"/> loss of smell | <input type="checkbox"/> numbness in fingers |
| <input type="checkbox"/> neck pain/stiffness | <input type="checkbox"/> loss of taste | <input type="checkbox"/> cold hands |
| <input type="checkbox"/> low back pain | <input type="checkbox"/> loss of memory | <input type="checkbox"/> cold feet |
| <input type="checkbox"/> mid back pain | <input type="checkbox"/> fatigue | <input type="checkbox"/> diarrhea |
| <input type="checkbox"/> eyes sensitive to light | <input type="checkbox"/> tension | <input type="checkbox"/> constipation |
| <input type="checkbox"/> pain behind eyes | <input type="checkbox"/> shortness of breath | <input type="checkbox"/> chest pain |
| <input type="checkbox"/> dizziness | <input type="checkbox"/> irritability | <input type="checkbox"/> nervousness |
| <input type="checkbox"/> fainting | <input type="checkbox"/> depression | <input type="checkbox"/> cold sweats |
| <input type="checkbox"/> ringing/buzzing ears | <input type="checkbox"/> sleeping problems | <input type="checkbox"/> anxious |
| <input type="checkbox"/> loss of balance | <input type="checkbox"/> numbness in toes | |
| <input type="checkbox"/> other _____ | | |

Prior to the accident have you **ever** had any of the symptoms similar to what you are experiencing now? **YES/NO**
If yes please explain (include any past falls, injuries, motor vehicle accidents, operations):

Do you notice any activities of your home daily routine that are different **now** than from **before** the accident? **YES/NO**
Do you notice any activities of your work daily routine that are different **now** than from **before** the accident? **YES/NO**
Activities that you are **unable** to do: _____
Activities that are **painful**: _____
Activities that are **difficult**: _____

Did you seek any medical help after the injury or have you seen anyone regarding this WBC claim? **YES/NO**
If Yes please check: Chiropractic Physiotherapy Medical doctor Other _____
How did you get there? _____ Date seen: _____
Were you examined? **YES/NO**
Were X-rays taken? **YES/NO** Body Part: _____
What treatment was given? bed rest brace adjustments physiotherapy medications other _____
Date of last treatment: _____

Patient Signature: _____

Doctors Signature: _____

Date: _____

NECK PAIN AND DISABILITY INDEX (Vernon-Mior)

Patient Name: _____ File#: _____ Date: _____

PLEASE READ THE INSTRUCTIONS:

This questionnaire has been designed to give the doctor information as to how your neck pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only one box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

<p>Section 1 – PAIN INTENSITY</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no pain at the moment. <input type="checkbox"/> The pain is moderate at the moment. <input type="checkbox"/> The pain is fairly severe at the moment. <input type="checkbox"/> The pain is very severe at the moment. <input type="checkbox"/> The pain is the worst imaginable at the moment. <p>Section 2 – PERSONAL CARE (washing, dressing etc.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can look after myself normally without causing extra pain. <input type="checkbox"/> I can look after myself normally but it causes extra pain. <input type="checkbox"/> It is painful to look after myself and I am slow and careful. <input type="checkbox"/> I need some help but manage most of my personal care. <input type="checkbox"/> I need help every day in most aspects of self care. <input type="checkbox"/> I do not get dressed and I wash with difficulty and stay in bed. <p>Section 3 – LIFTING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights but it gives me extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can lift very light weights. <input type="checkbox"/> I cannot lift or carry anything at all. <p>Section 4 – READING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can read as much as I want to with no pain in my neck. <input type="checkbox"/> I can read as much as I want to with slight pain in my neck. <input type="checkbox"/> I can read as much as I want to with moderate pain in my neck. <input type="checkbox"/> I can not read as much as I want because of moderate pain in my neck. <input type="checkbox"/> I can hardly read at all because of severe pain in my neck. <input type="checkbox"/> I cannot read at all. <p>Section 5 – HEADACHES</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no headaches at all. <input type="checkbox"/> I have slight headaches which come infrequently. <input type="checkbox"/> I have moderate headaches which come infrequently. <input type="checkbox"/> I have moderate headaches which come frequently. <input type="checkbox"/> I have severe headaches which come frequently. <input type="checkbox"/> I have headaches almost all the time. 	<p>Section 6 – CONCENTRATION</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can concentrate fully when I want to with no difficulty. <input type="checkbox"/> I can concentrate fully when I want to with slight difficulty. <input type="checkbox"/> I have a fair degree of difficulty in concentrating when I want to. <input type="checkbox"/> I have a lot of difficulty in concentrating when I want to. <input type="checkbox"/> I have a great deal of difficulty in concentrating when I want to. <input type="checkbox"/> I cannot concentrate at all. <p>Section 7 – WORK</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can do as much work as I want to. <input type="checkbox"/> I can only do as my usual work, but no more. <input type="checkbox"/> I can do most of my usual work, but no more. <input type="checkbox"/> I cannot do my usual work. <input type="checkbox"/> I can hardly do any work at all. <input type="checkbox"/> I cannot do any work at all. <p>Section 8 – DRIVING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can drive my car without any neck pain. <input type="checkbox"/> I can drive my car as long as I want with slight pain in my neck. <input type="checkbox"/> I can drive my car as long as I want with moderate pain in my neck. <input type="checkbox"/> I can not drive my car as long as I want because of moderate pain in my neck. <input type="checkbox"/> I can hardly drive at all because of severe pain in my neck. <input type="checkbox"/> I cannot drive my car at all. <p>Section 9 – SLEEPING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no trouble sleeping. <input type="checkbox"/> My sleep is slightly disturbed (less than 1 hour sleepless). <input type="checkbox"/> My sleep is mildly disturbed (1-2 hours sleepless). <input type="checkbox"/> My sleep is moderately disturbed (2-3 hours sleepless). <input type="checkbox"/> My sleep is greatly disturbed (3 – 5 hours sleepless). <input type="checkbox"/> My sleep is completely disturbed (5 – 7 hours sleepless). <p>Section 10 – RECREATION</p> <ul style="list-style-type: none"> <input type="checkbox"/> I am able to engage in all my recreation activities with no neck pain at all. <input type="checkbox"/> I am able to engage in all my recreation activities with some pain in my neck. <input type="checkbox"/> I am able to engage in most, but not all of my usual recreation activities because of pain in my neck. <input type="checkbox"/> I am able to engage in few of my usual recreation activities because of pain in my neck. <input type="checkbox"/> I can hardly do any recreation activities because of pain in my neck. <input type="checkbox"/> I cannot do any recreation activities at all.
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PAIN SCALE:

Rate the severity of your pain by checking one box on the following scale.

NO PAIN											Excruciating Pain
1	2	3	4	5	6	7	8	9	10		

LOW BACK PAIN AND DISABILITY QUESTIONNAIRE (Revised Oswestry)

Patient Name: _____ File#: _____ Date: _____

PLEASE READ THE INSTRUCTIONS:

This questionnaire has been designed to give the doctor information as to how your back pain has affected your ability to manage in everyday life. Please answer every section and mark in each section only one box which applies to you. We realize you may consider that two of the statements in any one section relate to you, but just mark the box which most closely describes your problem.

<p>Section 1 – PAIN INTENSITY</p> <ul style="list-style-type: none"> <input type="checkbox"/> The pain comes and goes and is very mild. <input type="checkbox"/> The pain is mild and does not vary much. <input type="checkbox"/> The pain comes and goes and is moderate. <input type="checkbox"/> The pain is moderate and does not vary much. <input type="checkbox"/> The pain comes and goes and is severe. <input type="checkbox"/> The pain is severe and does not vary much. <p>Section 2 – PERSONAL CARE (washing, dressing etc.)</p> <ul style="list-style-type: none"> <input type="checkbox"/> I would not have to change my way of washing or dressing in order to avoid pain. <input type="checkbox"/> I do not normally change my way of washing or dressing even though it causes pain. <input type="checkbox"/> Washing and dressing increase the pain but I manage not to change my way of doing it. <input type="checkbox"/> Washing and dressing increase the pain and I find it necessary to change my way of doing it. <input type="checkbox"/> Because of the pain I am unable to do some washing and dressing without help. <input type="checkbox"/> Because of the pain I am unable to do any washing and dressing without help. <p>Section 3 – LIFTING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can lift heavy weights without extra pain. <input type="checkbox"/> I can lift heavy weights but it gives me extra pain. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor. <input type="checkbox"/> Pain prevents me from lifting heavy weights off the floor, but I can manage if they are conveniently positioned, for example on a table. <input type="checkbox"/> Pain prevents me from lifting heavy weights, but I can manage light to medium weights if they are conveniently positioned. <input type="checkbox"/> I can only lift very light weights at most. <p>Section 4 – WALKING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I have no pain on walking. <input type="checkbox"/> I have some pain on walking but it does not increase with distance. <input type="checkbox"/> I cannot walk more than one km without increasing pain. <input type="checkbox"/> I cannot walk more than ½ km without increasing pain. <input type="checkbox"/> I cannot walk more than ¼ km without increasing pain. <input type="checkbox"/> I cannot walk without increasing pain at all. <p>Section 5 – SITTING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can sit in any chair as long as I like. <input type="checkbox"/> I can only sit in my favourite chair as long as I like. <input type="checkbox"/> Pain prevents me from sitting more than one hour. <input type="checkbox"/> Pain prevents me from sitting more than half an hour. <input type="checkbox"/> Pain prevents me from sitting more than ten minutes. <input type="checkbox"/> I avoid sitting because it increases pain straight away. 	<p>Section 6 – STANDING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I can stand as long as I want without pain. <input type="checkbox"/> I have some pain on standing but it does not increase with time. <input type="checkbox"/> I cannot stand for longer than one hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than ½ hour without increasing pain. <input type="checkbox"/> I cannot stand for longer than ten minutes without increasing pain. <input type="checkbox"/> I avoid standing because it increases the pain straight away. <p>Section 7 – SLEEPING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I get no pain in bed. <input type="checkbox"/> I get pain in bed but it does not prevent me from sleeping well. <input type="checkbox"/> Because of pain my normal night's sleep is reduced by less than ¼ of an hour. <input type="checkbox"/> Because of pain my normal night's sleep is reduced by less than ½ of an hour. <input type="checkbox"/> Because of pain my normal night's sleep is reduced by less than ¾ of an hour. <input type="checkbox"/> Pain prevents me from sleeping at all. <p>Section 8 – SOCIAL LIFE</p> <ul style="list-style-type: none"> <input type="checkbox"/> My social life is normal and gives me no pain. <input type="checkbox"/> My social life is normal but increases the degree of pain. <input type="checkbox"/> Pain has no significant effect on my social life apart from limiting my more energetic interests (e.g. dancing etc). <input type="checkbox"/> Pain has restricted my social life and I do not go out very often. <input type="checkbox"/> Pain has restricted my social life to my home. <input type="checkbox"/> I have hardly any social life because of the pain. <p>Section 9 – TRAVELLING</p> <ul style="list-style-type: none"> <input type="checkbox"/> I get no pain while travelling. <input type="checkbox"/> I get some pain while travelling but none of my usual forms of travel make it any worse. <input type="checkbox"/> I get extra pain while travelling but it does not compel me to seek alternative forms of travel. <input type="checkbox"/> I get extra pain while travelling which compels me to seek alternative forms of travel. <input type="checkbox"/> Pain restricts all forms of travel. <input type="checkbox"/> Pain restricts all forms of travel, except that done lying down. <p>Section 10 – CHANGING DEGREE OF PAIN</p> <ul style="list-style-type: none"> <input type="checkbox"/> My pain is rapidly getting better. <input type="checkbox"/> My pain fluctuates but overall is definitely getting better. <input type="checkbox"/> My pain seems to be getting better but improvement is slow at present. <input type="checkbox"/> My pain is neither getting better or worse. <input type="checkbox"/> My pain is gradually worsening. <input type="checkbox"/> My pain is rapidly worsening.
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PAIN SCALE:

Rate the severity of your pain by checking one box on the following scale.

NO PAIN																	Excruciating Pain
	1	2	3	4	5	6	7	8	9	10							

Beacon Hill Chiropractic and Massage

Payment Authorization Regarding WCB Claims

Please note, on occasion WCB does not authorize claims. It is your responsibility as our patient to pay for your chiropractic treatments.

As well, in the case that a total of three appointments are cancelled or an appointment is missed without 24 hours notice, treatment will be suspended until further review by your WCB Case Worker.

Name: _____

Signed: _____

Date: _____

Witness Name: _____ **Witness Signature:** _____

WCB Claim Number: _____

MVA / WCB Symptom Checklist
History (Patient/Claimant to Complete)

Patient Name: _____ Date: _____

1. Symptom Checklist

For each symptom, check YES (if present) or NO (if not present), and rate severity on a scale of 0 to 10 where indicated 0 is "No Pain" and 10 is "Pain as Bad as it Could Be."

Neck or shoulder pain YES NO

No Pain Pain as Bad as Could Be

0	1	2	3	4	5	6	7	8	9	10
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Upper or Mid-back pain YES NO

No Pain Pain as Bad as Could Be

0	1	2	3	4	5	6	7	8	9	10
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Low back pain YES NO

No Pain Pain as Bad as Could Be

0	1	2	3	4	5	6	7	8	9	10
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Headache YES NO

No Pain Pain as Bad as Could Be

0	1	2	3	4	5	6	7	8	9	10
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Pain in Arm(s) YES NO

No Pain Pain as Bad as Could Be

0	1	2	3	4	5	6	7	8	9	10
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Pain in Hand(s) YES NO

No Pain Pain as Bad as Could Be

0	1	2	3	4	5	6	7	8	9	10
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Pain in Face or Jaw YES NO

No Pain Pain as Bad as Could Be

0	1	2	3	4	5	6	7	8	9	10
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Pain in Leg(s) YES NO

No Pain Pain as Bad as Could Be

0	1	2	3	4	5	6	7	8	9	10
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Pain in Foot/Feet YES NO

No Pain

Pain as Bad
as Could Be

0	1	2	3	4	5	6	7	8	9	10
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Pain in Abdomen or Chest YES NO

No Pain

Pain as Bad
as Could Be

0	1	2	3	4	5	6	7	8	9	10
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Feeling of numbness, tingling in arms or hands YES NO

Feeling of numbness, tingling in legs or feet YES NO

Dizziness or unsteadiness YES NO

Vision problems YES NO

Hearing problems YES NO

Anxiety or worry YES NO

Nausea or vomiting YES NO

Difficulty swallowing YES NO

Problems concentrating YES NO

2. **Loss of consciousness** YES NO

3. **Have the injuries prevent you from carrying out any of the following:**

Explain

- Daily home activities
- Employment
- Schooling
- Sports or recreation
- Other

4. **Do you think your injury will:**

- get better soon
- get better slowly
- never get better
- don't know