



Workplace Injury Questionnaire

Services provided by Trevor Winzowski Chiropractic Corp.

185a Stone Bridge Crossing, Steinbach, MB R5G 2J2

Telephone 204-326-5800 Fax 204-346-1076

CLAIM # _____

Last name _____ First Name _____ Date of Birth _____

Today's Date: _____ (M/D/YY) Date of Accident: _____ (M/D/YY)

Employer name & address: _____

Your job title: _____

List primary complaints/injuries that developed as a result of the workplace accident:

- | | |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

Describe the accident in your own words:

Have you lost time from work because of these injuries? ☐ Yes ☐ No

If yes, how much time off? _____ Current work status? ☐ Full Duties ☐ Modified duties ☐ Not at work

Have you experienced injuries similar to those noted above within the past 2 years of this accident? (describe) _____

Within the past 2 years of this accident:

- | Yes | No | |
|--------------------------|--------------------------|--|
| ☐ | ☐ | 1. Have you had a previous WCB accident claim? |
| ☐ | ☐ | 2. Has your function or mobility been significantly impacted by arthritis? |
| ☐ | ☐ | 3. Have you undergone any treatment for cancer or other significant illness? |
| ☐ | ☐ | 4. Have you received supportive care (such as palliative care, etc.)? |
| ☐ | ☐ | 5. Have you been under active treatment for psychiatric or psychological conditions? |
| ☐ | ☐ | 6. Have you had any significant injuries that may affect your recovery from this accident? |

What injuries and how were you injured? _____

Have you seen any other healthcare providers for these injuries? ☐ Yes ☐ No

If yes, who? And when? _____

I hereby authorize the release of information and reports pertaining to these injuries to WCB for the duration of this claim:

Signature of Patient or Guardian

Date (M/D/YY)