ALL SEASONS CHIROPRACTIC

Workplace Injury Questionnaire

Services provided by Trevor Winzoski Chiropractic Corp.
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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 herby 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)