Work Place Injury History

Name:_____ Today's Date:_____

PHN:_____ Date of Injury:_____

Address (including postal code): _____

DOB (mm/dd/yy):_____ Phone Number:_____

WCB Claim #:_____

Employer's Name: _____

Operating Location:_____ Phone Num:_____

Who Rendered First Treatment?_____

Have you injured this area previously?_____ Missed Work Days:_____

Are you seeing any other healthcare provider?_____

Area of Injury:_____

What happened?_____

_____

_____

_____

Is it safe for you to return to work?_____ Is there light duty available?_____