

C504 WORKER'S PROGRESSIVE INJURY QUESTIONNAIRE

			Claim Number	
Worker's Name (Surname)	(First Name)	(Initial)	Date of Birth (Year / Month / Day)	
Address: Street		City/Town	Province	Postal Code:

To help us decide if your progressive injury is work related, we require answers to the following questions:

What is your job title?

Describe your typical work day.

How long has this been your typical work day?

Describe any changes to your work day which you feel could have caused or increased your symptom(s)?

Symptom(s)? (Please check appropriate box(es))

<input type="checkbox"/> Aching	<input type="checkbox"/> Weakness	<input type="checkbox"/> Burning
<input type="checkbox"/> Tingling	<input type="checkbox"/> Stiffness	<input type="checkbox"/> Other _____
<input type="checkbox"/> Numbness	<input type="checkbox"/> Pain	

When were the symptom(s) first noticed?

Location of symptom(s). (Please check appropriate box(es))

	Right	Left		Right	Left		Right	Left
Hand	<input type="checkbox"/>	<input type="checkbox"/>	Wrist	<input type="checkbox"/>	<input type="checkbox"/>	Neck	<input type="checkbox"/>	<input type="checkbox"/>
Shoulder	<input type="checkbox"/>	<input type="checkbox"/>	Elbow	<input type="checkbox"/>	<input type="checkbox"/>	Forearm	<input type="checkbox"/>	<input type="checkbox"/>
Fingers	<input type="checkbox"/>	<input type="checkbox"/>	Upper Back	<input type="checkbox"/>	<input type="checkbox"/>	Lower back	<input type="checkbox"/>	<input type="checkbox"/>
Other	_____							

Are you right or left hand dominant? Right Left

Tasks you perform in your job:

	Perform these tasks	Continuous?	How long do you perform the task each time?	How many times per day do you do the task?
	Yes	Yes		
Keyboarding	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mouse Usage	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Mail Sorting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Cashiering	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Lifting	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Carrying	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pushing	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Pulling	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____
Other _____	<input type="checkbox"/>	<input type="checkbox"/>	_____	_____

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Which of the work tasks cause or increase your symptom(s)? _____

Does the movement involve?

- Twisting motion
 Wringing motion
 Above shoulder level work
 Gripping motion

List tools/equipment used with the above motion: _____

Do you take scheduled breaks? _____

How long? _____ minutes How often? _____ minutes

List medical treatment obtained for this condition: *(including tests, x-rays, etc.)*

Doctor's Name	Address	Date of Treatment	Kind of Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

- Do you suffer from any of the following medical conditions?
- Diabetes Yes
 - Heart Condition Yes
 - Hypo/Hyper-Thyroidism Yes
 - Other _____ Yes

List all medications you are currently taking: _____

Have you ever had other injuries to the same body site? If yes, explain. *(Including claims with other Boards)* _____

List any hobbies, sporting, volunteer or recreational activities that you are involved in. _____

Is there any activity you can no longer do as a result of your injury? If yes, explain. _____

Do you have any other information about your injury? _____

Date: _____ Name (please print): _____ Signature: _____

If we need to obtain further information when is the best time for us to reach you? _____ Telephone Number: _____
(Including area code)

In order that this claim can be handled as quickly as possible, please return this information by either:
Fax 780-427-5863 or 1-800-661-1993 If you fax the report, do not send another by mail.
or Mail to: PO Box 2415, Edmonton AB T5J 2S5

**Any questions? Edmonton: 780-498-3999, Calgary: 403-517-6000,
 Toll Free: anywhere in Alberta 1-866-922-9221 and then dial the office nearest you.**