Workers' Compensation Board
Alberta
P.O. BOX 2415
EDMONTON AB T5J 2S5
Fax: (780) 427-5863
1-800-661-1993

C504
WORKER'S PROGRESSIVE INJURY QUESTIONNAIRE

Claim Number

Will you be off work due to this injury? ☐ Yes ☐ No

Personal Health Number

Worker's Name *(Surname)* *(First Name)* *(Initial)*

Date of Birth *(Year / Month / Day)*

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})*

☐ Aching ☐ Weakness ☐ Burning
☐ Tingling ☐ Stiffness ☐ Other _____
☐ Numbness ☐ Pain

When were the symptom(s) first noticed? _____

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

	Right	Left		Right	Left		Right	Left
Hand	☐	☐	Wrist	☐	☐	Neck	☐	☐
Shoulder	☐	☐	Elbow	☐	☐	Forearm	☐	☐
Fingers	☐	☐	Upper Back	☐	☐	Lower back	☐	☐

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	No	Yes	No		
Keyboarding	☐	☐	☐	☐		
Mouse Usage	☐	☐	☐	☐		
Mail Sorting	☐	☐	☐	☐		
Cashiering	☐	☐	☐	☐		
Lifting	☐	☐	☐	☐		
Carrying	☐	☐	☐	☐		
Pushing	☐	☐	☐	☐		
Pulling	☐	☐	☐	☐		
Other _____	☐	☐	☐	☐		

Worker's Name *(Surname)*	*(First Name)*	*(Initial)*	Claim Number

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	☐ No
Heart Condition	☐ Yes	☐ No
Hypo/Hyper-Thyroidism	☐ Yes	☐ No
Other _____	☐ Yes	☐ No

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? _____

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: WCB, PO Box 2415, Edmonton, AB T5J 2S5

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