

Work Safe BC Patient information

Please fill out the information to the best of your knowledge.
It is understood that you may not recall all relevant information at this time.

Name: _____ Birthdate: _____
first initial Last month day year

Address: _____
number street city prov postal code

Phone Number: _____ BC Care Card: _____

Occupation: _____ WCB Claim Number: _____

Employer's Name: _____

Business Name

Address: _____
number street city prov postal code

Work Phone Number: _____

Location or Job Site of Accident: _____

Date and Time of Injury: _____

First Doctor Seen for Injury: _____ When: _____

Were you seen at a Hospital or Walk in Clinic? _____
yes no

What is the name of the Hospital or Walk in Clinic: _____

Were any x-rays, CT Scan, or MRI taken? _____
yes no

What caused the accident: _____

Have you ever had pain in this area before? _____
yes no

Have you ever had an x-ray of this area before? _____
yes no

If yes, was it before _____, or after _____ the accident.

Have you lost any time off work? _____
yes no

Date you returned to work: _____
day month year

****NOTE: OUR OFFICE MUST BE NOTIFIED OF ANY FURTHER LOSS OF WORKING TIME.**

Problem areas: Check any areas which are injured due to this incident

Head _____	Neck _____	Shoulders _____
Upper Back _____	Mid Back _____	Low Back _____
Arm _____	Elbow _____	Wrist _____
Leg _____	Knee _____	Ankle _____

Other: _____

Have you reported your injury to Work Safe BC? _____
Has your employer reported your injury to Work Safe BC? _____

Are you currently seeing any other practitioner for treatments with regards to your injury? _____
If yes, Who _____ Type of Practitioner _____

*****Work Safe BC will only cover one type of care during your claim. If you choose to see more than one health care provider/practitioner your claim will be denied.**

Work Safe BC will allow a maximum of 8 weeks coverage for Chiropractic treatment under one claim. If for some reason your claim is disallowed you are responsible for full payment of your Chiropractic Treatments.