CHIROPRACTIC *Health* CENTRE

Please fill out this form completely, if anything doesn't apply please mark with N/A.

WORKER'S COMPENSATION PRELIMINARY QUESTIONS

Last name: _____ First name: _____

WCB Claim #: _____ Date of injury: _____ (mm/dd/yyyy)

Have you lost any time at work? **Y** **N** Are you currently working? **Y** **N**

If yes: ☐ F/T ☐ P/T

Occupation/Job Title: _____

Employer's Name: _____

Employer's Address: _____

_____

Employer's phone #: _____

Please list your specific critical job requirements:

_____

Have you seen a doctor for this condition? Who? _____

Describe fully what happened to cause the injury:

_____

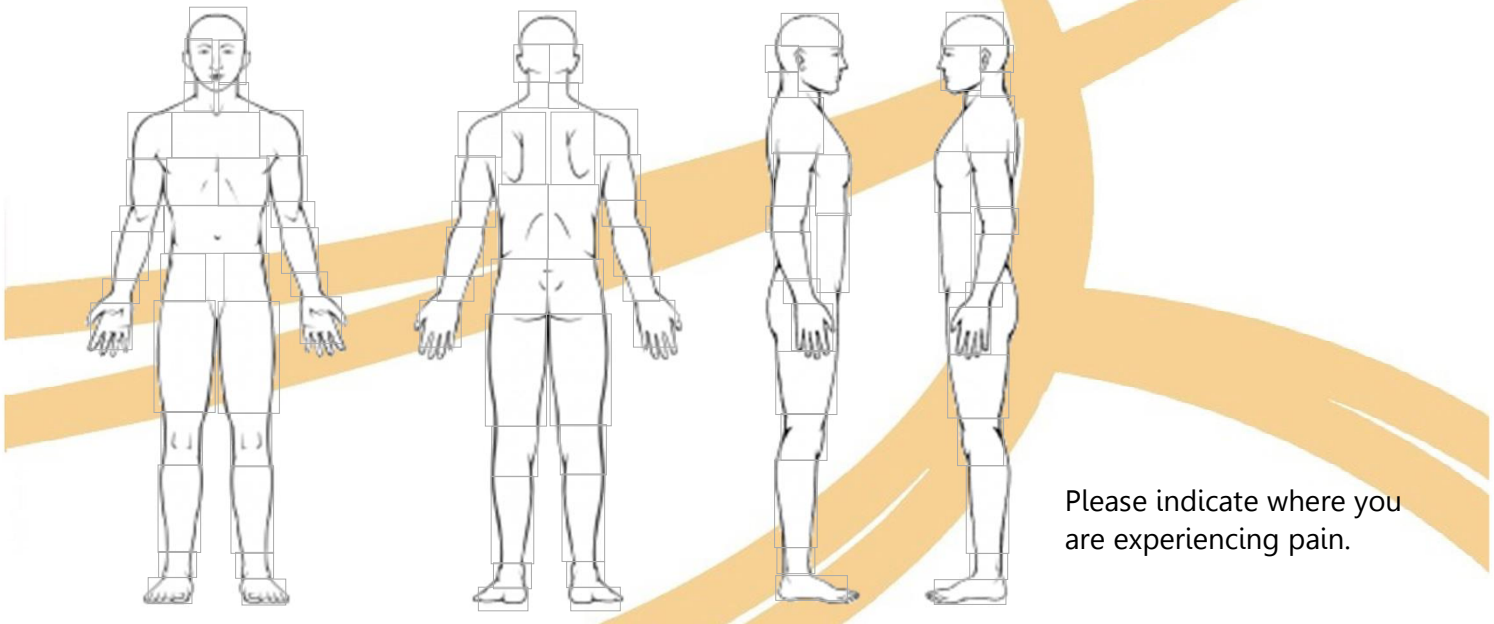
_____

_____

_____

_____

Have you had similar symptoms in the past? **Y** **N**



Please indicate where you are experiencing pain.

Ph: (403) 277-9339
Fx: (403) 277-2447
www.chiro-doctor.com
2713 Centre St NW
Calgary, AB T2E 2V5

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