WCB QUESTIONNAIRE

Client Name: _____

1. Your case manager: _____ Phone Number: _____

2. When you injured yourself, did you experience discomfort immediately? Yes No

3. Did you see a Medical Doctor immediately: No Yes (Emergency)
Yes (Walk-in clinic) Yes (Family Doctor)

4. If no, when did you see a Doctor? _____/_____/_____
MM DAY YEAR

5. Do you have a Doctors' referral for Physical Therapy? Yes No

6. Did your Doctor complete a WCB Report? Yes No

7. Have you had this injury before? Yes No If yes, did you have Physical Therapy? Yes No

8. Did you complete and send the WCB incident report? Yes No

9. Did your employer complete a WCB incident report? Yes No

10. Have you missed work due to your injury? Yes No

11. Are you currently working? Yes No

12. Are you required to frequently lift/pull/push: 0 – 10 lbs 11 – 25 lbs 26 – 50 lbs
51 – 100 lbs over 100 lbs Not Required

13. Are you required to occasionally lift/pull/push: 0 – 10 lbs 11 – 25 lbs 26 – 50 lbs
51 – 100 lbs over 100 lbs Not Required

14. What are you currently able to lift/pull/push: 0 – 10 lbs 11 – 25 lbs 26 – 50 lbs
51 – 100 lbs over 100 lbs Not Required

15. Are you on modified duties? Yes No

16. Do you feel your injuries are limiting you at work? Yes No