Clayton Heights
CHIROPRACTIC

WORKER'S COMPENSATION QUESTIONNAIRE

Salutation: Mr. Mrs. Miss Ms. _____ First Name: _____ Last Name:_____ ___
Address: _____ _____ City: _____
Province: _____ Postal Code: _____ E-Mail Address: _____
Home Phone: _____ Work Phone: _____
CARE CARD# (PHN): _____
Occupation: _____ Type of Work: _____
Employer Name: _____ Employer Phone: _____
Employer Address: _____

WCB Claim Number: _____
WCB Adjuster's Name: _____
WCB Adjuster's Phone: _____

Location where injury occurred: _____

Date and time of this injury: _____20___ at _____ AM / PM

Who rendered first treatment? _____

Location: _____

Were you hospitalized as a result of this injury? ☐ Yes ☐ No
If yes, when and where? _____

State how the injury occurred and areas affected: _____
_____
_____

Have you missed any days of work? ☐ Yes ☐ No If yes, how many?_____

Have you had X-Rays taken regarding this injury? ☐ ☐

Yes No
If yes, when and where? _____