# WCB INTAKE FORM 2

| WCB CLAIM NUMBER: | DATE OF INJURY (MM-DD-YYYY) | DATE OF BIRTH: | ALBERTA HEALTH CARE NO: |
|---|---|---|---|
| | | | |

| HAVE YOU LOST TIME FROM WORK (_____Y/_____N) | HAVE YOU RETURNED TO WORK? (___Y/____N) |
|---|---|
| IF YES: _____DAYS/ _____WEEKS | IF YES: DATE OF RETURN TO WORK (MM-DD-YYYY) _____ |
| **WHAT BODY PART:** | **TYPE OF INJURY: (I.E. STRAIN, FRACTURE)** |
| | |

| COMPLAINT/SYMPTOMS: |
|---|
| |
| **HAVE YOU EVER HAD A SIMILAR PROBLEM? ☐ NO ☐ YES IF YES, PLEASE DESCRIBE:** |
| |

## REFERRAL DOCTOR

| DOCTOR WHOM YOU FIRST REPORTED THIS PROBLEM:NAME & CLINIC | FIRST DATE OF DOCTOR CONTACT (YYYY-MM-DD): |
|---|---|
| | |
| **DATE OF DOCTOR REFERRAL:** | **DOCTOR PHONE:** |
| | |

| FAMILY DOCTOR: (IF DIFFERENT THAN ABOVE) |
|---|
| |

(IF YOU HAVE A REFERRAL SLIP PLEASE PROVIDE ALONG WITH THIS FORM)

## EMPOLYMENT INFORMATION

| EMPLOYER: | JOB TITLE: |
|---|---|
| | |
| **EMPLOYER CONTACT PERSON: (SUPERVISOR, HR)** | **EMPLOYER CONTACT NUMBER:** |
| | |

| EMPLOYER ADDRESS: |
|---|
| |

Patient Signature: _____ Date: _____

Witness Signature: _____ Date: _____