WSCC Workers' Safety & Compensation Commission

Worker's Repetitive Strain Injury (Upper Limbs) Questionnaire

COMPLETE THIS FORM TO HELP US DETERMINE IF YOUR PROBLEM IS WORK-RELATED.

WSCC Claim Number:

Worker Information

Last Name:	First Name:	
Mailing Address (include postal code):	Community:	Telephone (include area code):
Residential Address:	Date of Birth: YY | MM | DD	Sex: ☐ Male ☐ Female
Employer's Name:	Worker's Occupation:	

Questions	Responses				
Job History					
1. Current job:					
2. How long have you been doing this job?					
3. Previous jobs with similar duties?					
4. Second job?					
5. Is your employer aware of your ongoing problems? When did you inform your employer?					
6. Work activities that contribute to your claimed injury:					
7. Repetitive tasks performed in your job:	**Task 1**	**Task 2**	**Task 3**	**Task 4**	**Task 5**
• **Weight involved with task**	1.				
• **Force applied to do task**	2.				
• **Right or left hand or both**	3.				
• **Hours per day**	4.				
• **Continuous hours performed**	5.				
• **Frequency/length/number of breaks**	6.				
• **Vibratory tools used**	7.				

Questions	Responses
Job History Continued	
8. Movements involved:	Twisting motion ☐ Wringing motion ☐ Above shoulder level work ☐ Gripping motion ☐
9. Recent changes in type or number of tasks performed?	
10. Overtime or extraordinary work?	
Injury History	
11. Describe your physical injury, including symptoms.	
12. Location of symptom(s):	**Hand** R L **Wrist** R L **Neck** R L **Shoulder** R L **Elbow** R L **Forearm** R L **Fingers** R L
13. Date symptoms began:	
14. Activities performed at symptom onset:	
15. Do symptoms change when you are not at work? How?	
16. When do these symptoms bother you?	At work ☐ At night ☐
	Immediately when doing:
	Other:
17. What decreases symptoms?	
18. What increases symptoms?	

Questions	Responses			
Injury History Continued				
19. Treatments, investigations or consultations:	**Doctor**	**Location**	**Date**	**Treatment/Test**
20. Previous similar problems:				
21. Do you have any other health problems? Medications?				
22. Are you right-handed or left-handed?	Right ☐ Left ☐			
23. Are there recreational activities or hobbies you are no longer able to perform? If yes, please list activities.				
24. Do you operate a computer outside of work?	Yes ☐ No ☐ Hours per week:			
25. What do you think caused your condition?				

WORKER’S CONSENT

I hereby claim compensation for work-related injuries or disease.

<u>**Information Sharing**</u> – I understand the WSCC uses the above information about me for the sole purpose of conducting an investigation into this claim. I also understand the WSCC will need to gather more information about my work incident and medical and work history to administer my claim. For that specific purpose only, the WSCC may disclose some personal information to employers, medical personnel and other relevant third parties.

I authorize the WSCC to provide and gather such information from all necessary sources, including hospital and doctors’ records, and employer records.

<u>**Information Accuracy**</u> – I understand incomplete information from me may delay my claim, and untrue information from me is unlawful.

I declare the information above is true and accurate. I understand it may be a criminal offence to make a false claim, or to work and earn income while receiving workers’ compensation without telling the WSCC.

Signature of Worker: ______________________________ Date: ______________________________

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or

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Ce formulaire est disponible en français.
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