WORKERS' COMPENSATION BOARD
Northwest Territories and Nunavut

Worker's Repetitive Strain Injury (Upper Limbs) Questionnaire

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

WCB 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 ❑ M ❑ F	
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.				

Job History con't

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?	

Injury History con't				
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?				

FOR QUESTIONS, CALL 1-800-661-0792 OR 920-3888.

Signature of Worker: ______________________ Date: ______________