DR.ATOOSA
CHIROPRACTOR
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P: (416) 222-7775
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St. Gabriel Medical Centre
650 Sheppard Avenue East
North York, ON M2K 3E4

Confidential WSIB Intake Form

ACCIDENT INFORMATION

Date of Injury _____Time _____❒ AM ❒ PM

Location ❒ At Work ❒ Other _____Employer Name _____

Address _____ Postal Code_____

Phone _____ Fax _____Contact Name _____

Social Insurance Number_____ Have you reported the accident to your employer yet? ❒YES ❒NO

WSIB Claim # (if known) _____ Name of Adjudicator assigned to you (if known)_____

Phone _____ Fax _____

Describe what happened:

_____
_____
_____
_____
_____
_____

INJURY DETAILS

Did lifting an object cause this injury?	❑ Above head ❑ Waist level ❑ Bending ❑ Twisting ❑ Heavy load	
Was this injury caused by a fall?	❑ Yes ❑ No	❑ Stairs ❑ Carrying load ❑ Obstacle involved ❑ Awkward position ❑ Ice ❑ Grease ❑ Wetness
Was this injury caused by overuse?	❑ Yes ❑ No	
What limitations have you noticed since the accident?	❑ Can't lift ❑ Can't clean ❑ Can't cook ❑ Can't look after children	❑ Can't study ❑ Can't sit for long ❑ Can't concentrate ❑ Can't work ❑ Other
Have you lost any days from work?	❑ Yes ❑ No	List Dates:

Continued…

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INJURY DETAILS *cont'd*

Do you have an attorney advising you on this case?	❑ Yes ❑ No	Name Phone
Have you seen any other health professional for this injury?	❑ Yes ❑ No	Name Phone
Did they fill out WSIB forms?	❑ Yes ❑ No	

PLEASE READ AND SIGN THE FOLLOWING

The above statements are true to the best of my knowledge.
If for any reason WSIB will not accept or discontinue my claim, I am responsible for all charges.

Signature: _____ Date: _____

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CONFIDENTIAL PSYCHOLOGICAL SCREENING QUESTIONNAIRE

The use of this form is for referral purposes only and will be kept strictly confidential.

Name: _____

Please check the box if you have experienced any of the following since your motor vehicle accident?

►Any nervousness driving or being a passenger in a vehicle? □Yes □ No

►Difficulty coping with a pain condition and/or emotional difficulties which have affected ones ability to function within your respective home, social or occupational environment? □Yes □ No

►Sleep disturbances (lack of sleep, trouble initiating sleep, and/or trouble maintaining sleep) as a result of functional, emotional, and/or interpersonal difficulties? □Yes □ No

►Anxiety represented by increased arousal, nightmares, flashbacks, constant thoughts, avoidance and/or agitation? □Yes □ No

►Experiencing any mood or personality disturbances related to an accident, current situation, or current limitations (irritability, agitation, depression, anxiety, relationship difficulties, etc.)? □Yes □ No

►Disengagement from regular activity levels causing distress? □Yes □ No

►Suicidal ideation and/or significant emotional instability? □Yes □ No

Have you been seen for a psychological assessment related to this accident? □Yes □ No

INITIAL _____ DATE: _____