



WORK SAFE BC Client Intake Form

Employment and Claim Information

(Patient First Name) (Patient Last Name) Email: _____

Occupation: _____ Date of Injury: MM/DD/YYYY Claim Number: _____

Employer Name: _____ Employer Phone: _____

Supervisor Name: _____ Supervisor Phone: _____

Work Status & Schedule

Current Employment Status: Working Not Working Last Day Worked: MM/DD/YYYY

Work Schedule (Before Injury)	
Working days per week:	Working hours per week:
Work Schedule (After Injury)	
Working days per week: <input type="checkbox"/> Modified <input type="checkbox"/> Regular	Working hours per week: <input type="checkbox"/> Modified <input type="checkbox"/> Regular
Duties at Work: <input type="checkbox"/> Modified <input type="checkbox"/> Regular	

Functional Capacity (Tolerance without Pain) *Please indicate your current pain-free limits for the following tasks:*

Functional Activity	Weight Limit (lbs)	Functional Activity	Duration (Time / Steps)
Lifting: Above Shoulder	_____ lbs	Standing	
Lifting: Floor to Waist	_____ lbs	Walking	
Lifting: Shoulder to Waist	_____ lbs	Sitting	
Pushing / Pulling	_____ lbs	Climbing Stairs	
Others:			