



**FOOT AND ANKLE
QUESTIONNAIRE**
CLAIMS DIVISION
SFN 51817 (04/2022)

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Fraud and Safety Hotline 800-243-3331
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SECTION 1 – Employee's information		
Claim number	Employee's (First name)	(Last name)
Body part(s)		
SECTION 2 – Current condition		
When did you first notice problems with your foot and/or ankle?		
What were you doing when the problems occurred?		
Describe your current job duties.		
How much time per day is spent performing the described duties?		
How long have you worked for your current employer?		
How long have you done this type of work?		
If you changed positions within the company, describe the physical activities of the prior position(s).		
When did you become aware your condition was related to your work?		
SECTION 3 – Prior condition		
Have you ever injured your foot and/or ankle before? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, how did the injury occur?		
If yes, when did the injury occur?		
If yes, where did you treat?		
Have you ever treated previous symptoms on your own (Example: using a brace, exercise, orthotics, or over-the-counter medication)? <input type="checkbox"/> Yes <input type="checkbox"/> No		
If yes, describe		

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Have you been treated by an orthopedist or podiatrist (foot doctor)? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list the name(s) and addresses of medical provider(s) who treated you for these conditions.
Have you had x-rays, MRI's or CT scans of your feet or ankles? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list the date, where the imaging was done, and the results.
Do you have any congenital foot deformity since birth (Example: flat feet, high arches, etc)? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe.
Have you been diagnosed with diabetes or arthritis? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe.
Have you had recent trauma to your feet or ankles? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, describe.
Do you participate in sports or hobbies outside of work? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list the sport or hobby and describe how often you do them.
Do you walk or run as part of an exercise program? <input type="checkbox"/> Yes <input type="checkbox"/> No
How much time per day is spent walking or running?
How much time per week is spent walking or running?
How far do you walk or run?
List exercise besides walking or running.
Have you been told your recent symptoms are related to your work duties? <input type="checkbox"/> Yes <input type="checkbox"/> No
If yes, list the name(s) and addresses of medical provider(s) who told you your recent symptoms are related to your work duties.

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List the date the medical provider(s) told you your recent symptoms are related to your work duties.

What type of footwear do you normally wear at work?

What type of footwear do you normally wear outside of work?

Women: Are you post-menopausal?
 Yes No

SECTION 3 – Release of information/fraud warning/signature

Release of information
 I understand and agree that North Dakota law determines all my rights and obligations to and from WSI. I authorize any medical provider or facility, any insurance company, including workers' compensation relating to work injuries, any law enforcement or military agency, any government benefit agency including the Social Security Administration, and any educational agency or institution to release to WSI, its agents and attorneys, any and all information or records, including all prior records as well as those pertaining to mental health, alcohol, or drug abuse, and HIV/AIDS/AIDS-related illness. I authorize healthcare providers to respond to WSI regarding my injury, including request for conclusions and opinions not otherwise contained within existing medical records. In addition, I authorize any education agency or institution to release to WSI any and all "educational records" as defined by 20 U.S.S 21 Sec. 1232g.

This authorization lasts for 1 year after the date signed unless I enter a different expiration date here _____.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.

WSI is exempt from HIPAA regulations. I authorize WSI to release any information or records about my claim to third parties or their insurers for the purpose of resolving claims against third parties. I authorize the release of any medical information related to my claim to my employer.

Fraud warning
 Any person claiming benefits or compensation from WSI who files a false claim, or makes a false statement, or fails to notify WSI as to the receipt of income or an increase in income from employment, in connection with any claim or application for workers' compensation benefits will forfeit any future benefits and may be guilty of a felony which is punishable by imprisonment, substantial fines, or both. These criminal penalties are applicable to all persons dealing with WSI, including injured employees, employers, medical providers, and attorneys.

Signature
 By signing this form, I acknowledge that I have read and understand the release of information and fraud warning. I understand that falsifying this claim or making a false statement regarding this claim may be a felony, punishable by substantial fines and imprisonment. I authorize the release of information and agree that statements in this form are true and accurate.

Employee's signature	Date
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