



North Dakota Workforce
Safety & Insurance

**PRIOR INJURY & PRE-EXISTING
CONDITION QUESTIONNAIRE**
CLAIMS DIVISION
SFN 51153 (04/2022)

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Toll Free Fax 888-786-8695
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Fraud and Safety Hotline 800-243-3331
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SECTION 1 – Injured employee's information			
Claim number		Injured employee's (First name)	(Last name)
Body part(s)			
SECTION 2 – Past medical treatment to claimed body area(s)			
Have you ever had any previous problems or treatment, in or around the area(s) of your body listed above (work-related or non-work related)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, list the date(s) and name(s) and addresses of the medical provider(s). If exact date is not known, use the first of the month or first of the year as an approximate date. (Example: 01/01/2021.)			
Date	Name	Address	Telephone number
If yes, which body part(s)?			
If yes, how did the injury or condition occur?			
If yes, when did the injury or condition occur?			
If yes, what did the medical provider tell you your diagnosis was (Example: fracture, sprain, dislocation, tendonitis, etc.)?			
When did you last receive treatment (Example: office visit, injection, medication, etc.) or see a medical provider for this past problem, condition, or injury?			
Have you ever had any diagnostic testing of any kind done on the above listed body part(s) (Example: MRI, CT scan, X-ray, EMG, Ultrasound, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, list the date(s) and the facility where the diagnostic testing was done and describe the results. If exact date is not known, use the first of the month or first of the year. (Example: 01/01/2021.)			
Date	Name	Address	Telephone number
Have you ever received chiropractic treatment (work-related or non-work related)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, list the date(s) and name(s) and addresses of the chiropractor(s). If exact date is not known, use the first of the month or first of the year. (Example: 01/01/2021.)			
Date	Name	Address	Telephone number
Have you ever received physical therapy/occupational therapy (work-related or non-work related)? <input type="checkbox"/> Yes <input type="checkbox"/> No			
If yes, list the date(s), name(s), and addresses of the therapist(s). If exact date is not known, use the first of the month or first of the year. Example: 01/01/2021.)			
Date	Name	Address	Telephone number
Have you ever treated previous symptoms on your own (Example: using a brace, exercise, over-the-counter medication, etc.)? <input type="checkbox"/> Yes <input type="checkbox"/> No			

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Claim number	Injured employee's (first name)	(Last name)
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If yes, describe.

Explain if you feel your past problem, condition or injury is different from your current problem for which you are filing this claim.

SECTION 3 – Past general medical treatment

In the past, has any medical provider restricted you from performing certain physical activities at work or at home because of any injury, medical condition, or health problem(s); work-related or non-work related?
 Yes No

If yes, list restriction(s), medical provider(s) who initiated the restriction(s) and date(s).

List the names and addresses of all medical providers that you have seen for any of your routine medical care in the past. If exact date is not known, use the first of the month or first of the year. (Example: 01/01/2021.)

Date	Name	Address	Telephone number

Have you ever filed a workers' compensation or personal injury claim, in any state, for any injuries or health problems?
 Yes No

If yes, in what state(s)? Name of insurance company

When was the claim filed? Type of injury?

Have you ever received a permanent disability, impairment, or percentage rating in the past for any injury or health problems?
 Yes No

If yes, in what state(s)? Name of insurance company

When? Type of injury?

SECTION 4 – Release of information

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 this authorization may be revoked at any time in writing. Revocation of this authorization will not apply to any information released prior to receipt of my written revocation of this authorization.

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 worker's 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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