



**REPETITIVE MOTION  
QUESTIONNAIRE**  
CLAIMS DIVISION  
SFN 50306 (02/2015)

1600 E Century Ave, Ste 1  
PO Box 5585  
Bismarck ND 58506-5585  
**Telephone 800-777-5033**  
Toll Free Fax 888-786-8695  
TTY (hearing impaired) 800-366-6888  
Fraud and Safety Hotline 800-243-3331  
www.workforcesafety.com

Injured Worker's Name	Claim Number	<b>PAGE 1</b>
Body Part	Mailing Date	

**DIRECTIONS:** PLEASE PRINT OR TYPE USING BLACK OR BLUE INK. Read and answer each question. If additional space is needed to respond, use the back of these pages or a separate sheet of paper. Please be sure to sign and date the last page and **return this questionnaire to Workforce Safety & Insurance at the address listed above within 14 days from the mailing date listed above.** Injured workers are subject to penalty for failure to comply or for any false statement.

1.
  - a. Describe, as best you can, the motion/movements of your shoulder (s), arm(s), wrist(s), hand(s), and elbow(s) required by your job (including computer usage).
  - b. How many hours/minutes per day/week do you spend performing the described movements?
  - c. How long have you worked for your present employer?
  - d. If employed with this employer less than one year, please list previous employer(s), how long employed with the previous employer(s), and a description of the job(s) performed at the previous employer(s).
  - e. Do you operate any vibrating machinery?  Yes  No
  - f. Have you always done this type of work (the current duties outlined in question 1a) for your employer?  
 Yes  No  
 If you moved from another position in the company, please provide the details of the prior job, how long you were in the prior job, and when you moved to your current job.
  
2.
  - a. Do you work more than one job or own a home-based business?  Yes  No  
**If yes**, please complete the following for each job.
  - b. What is the name, address, and phone number of your employer? How long have you worked there?
  - c. Please describe your work duties.
  - d. Do you farm / ranch?  Yes  No

Claim Number	Injured Worker
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3.
  - a. Have you ever injured (i.e. fractured, sprained) your shoulder(s), arm(s), wrist(s), hand(s), or elbow(s) before?     Yes         No
  - b. **If yes**, how many times?
  - c. **If yes**, where did the injury occur?
  - d. **If yes**, how did the injury occur?
  - e. Explain, on a separate sheet if needed, any other details related to prior shoulder, arm, wrist, hand or elbow injuries.
  - f. Have you ever treated previous symptoms on your own, such as using a brace, exercises, over the counter medications, etc?     Yes         No  
**If yes**, please explain
  
4.
  - a. Have you had any Electromyography (EMG)/Nerve Conduction tests?     Yes         No
  - b. **If yes, please list dates and results:**
  
5.
  - a. Do you experience any pain when bending your hand(s) forward?     Yes         No  
**If yes**, please explain:
  - b. Do you experience any pain when bending your hand(s) backward?     Yes         No  
**If yes**, please explain:
  
6.
  - a. Have you ever had x-rays taken for any reason on your shoulder(s), arm(s), wrist(s), hand(s) or elbow(s)?  
 Yes         No  
**If yes**, please explain:
  - b. Do you know of any x-ray findings that show a fracture in your shoulder(s), arm(s), wrist(s), hand(s) or elbow(s)?     Yes         No  
**If yes**, please explain:
  - c. Do you know of any x-ray findings that show arthritis in your shoulder(s), arm(s), wrist(s), hand(s) or elbow(s)?     Yes         No  
**If yes**, please explain:

Claim Number	Injured Worker
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7. What is your dominant hand?       Right       Left
8. a. Have you had or do you have any hobbies, i.e. knitting, crocheting, cross-stitching, gardening, canning, piano?       Yes       No  
**If yes**, describe them and state how often you do them.
- b. How many hours a day do you play video or computer games?
- c. How many hours a day do you use your home computer?
- d. How many hours a day do you use your cellular phone/smart phone/tablet?
1. How many texts do you send per day?
9. a. Have you or do you participate in any sports, i.e. fishing, bowling, weightlifting, darts?       Yes       No  
**If yes**, describe the sport and how often you participate.
- b. Do you participate in a regular exercise program?       Yes       No  
**If yes**, please explain the activity and frequency of the exercise.
10. a. Have you ever been diagnosed as having, or maybe having, diabetes, kidney disease, liver disorder, thyroid disease, or alcoholism?       Yes       No      **If yes**, explain:
- b. Please provide the names and addresses of all medical doctors or other health care professionals who have treated you for this condition. (Continue on back if needed.)

Complete Name	Address	City, State, Zip	Phone	Time Frame

11. Have you ever had any neck problems or injuries?       Yes       No  
**If yes**, please list any medical doctor, chiropractor, physical therapist, occupational therapist, or other health care professional that you treated with for your neck problems or injuries. (Continue on back if needed.)

Complete Name	Address	City, State, Zip	Phone	Time Frame

12. a. Have you ever been involved in an automobile accident?       Yes       No  
**If yes**, what body part was injured and when did the accident occur?
- b. Did you need to seek medical treatment for the auto accident?       Yes       No

Claim Number	Injured Worker
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- 13. a. Have you ever been told that the pain in your shoulder(s), arm(s), wrist(s), hand(s) or elbow(s) is related to your work duties?       Yes       No
- b. **If yes**, what is the name of the physician who told you that your problem(s) was/were related to your work duties?
- c. What was the approximate date the physician told you?
  
- 14. Please provide any other information that may be helpful in determining the cause or extent of your pain or injury.
  
  
- 15. a. **Women:** Have you had any post menopausal symptoms or gynecological abnormalities?       Yes       No
- b. Have you taken oral contraceptives or similar hormones?       Yes       No
- c. Are you or have you been pregnant?       Yes       No
- d. **If yes to question 15c**, how long ago was your last pregnancy?
  
- 16. a. Have you had shoulder, arm, wrist, and/or elbow surgery(s)?       Yes       No
- b. **If yes**, what body part(s) (specify right or left)? When did you have the surgery? At what medical facility?
- c. **If no**, when do you expect to have surgery? At what medical facility?

**UPON COMPLETION OF THIS FORM, PLEASE SIGN, DATE, AND RETURN IT TO:**

Attn: Claims Department  
 Workforce Safety & Insurance  
 PO Box 5585  
 Bismarck, ND 58506-5585

**Fraud Warning for Filing False Claims**

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 the Fund, including injured workers, employers, medical providers, and attorneys.

Injured Worker's Signature	Date
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