FOOT AND ANKLE QUESTIONNAIRE

CLAIMS DIVISION
SFN 51817 (08/2014)

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TTY (hearing impaired) 1-800-366-6888
Fraud and Safety Hotline 1-800-243-3331
www.WorkforceSafety.com

Injured Worker's Name	Claim Number	Mailing Date	**PAGE 1**

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 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. Date and time when you first noticed problems:
   Date: **Time:**

2. What were you doing when problems occurred?

3. Describe, as best you can, your current job duties.

4. How many hours/minutes per day/week do you spend performing the described duties?

5. How long have you worked for your present employer?

6. Have you always done this type of work (the current duties outlined in question #3) for your employer?
   ☐ Yes ☐ No
   If you moved from another position in the company, please provide the details of the prior job, how long were you in the prior job, and when you moved to your current job.

7. Has there been a recent change in any of your required job duties? ☐ Yes ☐ No
   If 'yes', please explain the change and when it occurred.

8. Have you had any injuries, conditions or problems to your feet/ankle(s) prior to the recent symptoms?
   ☐ Yes ☐ No If 'yes', how many times?

   Where did the injury occur?

   How did the injury occur?

   If necessary, provide any other details related to any prior foot injuries.

Injured Worker's Name	Claim Number

9. Have you ever had x-rays taken, for any reason, of your feet? ☐ Yes ☐ No
   If 'yes', please explain.

10. Do you know of any findings that show any abnormalities such as bone spurs, etc?
    ☐ Yes ☐ No

11. What is your current height and weight? Height: Weight: lbs.

12. Have you experienced any weight gain or loss within the past year? ☐ Yes ☐ No
    If 'yes', please explain when this occurred and how much weight was gained or lost.

13. Do you participate in any sports/hobbies outside of work? ☐ Yes ☐ No
    If 'yes', please explain them.

14. Do you walk outside of work as part of an exercise program? ☐ Yes ☐ No
    If 'yes':
    How often do you walk?
    How much time do you spend walking for exercise per day?
    How far do you walk?

15. Do you do any type of exercise besides walking? ☐ Yes ☐ No
    If 'yes', please explain.

16. Have you been told you have any type of congenital foot deformity from birth? ☐ Yes ☐ No
    If 'yes', please explain.

17. Have you been diagnosed with diabetes? ☐ Yes ☐ No Arthritis? ☐ Yes ☐ No
    If 'yes', please explain.

18. Do you have flat feet? ☐ Yes ☐ No High arches? ☐ Yes ☐ No

19. Have you had any recent trauma to your feet? ☐ Yes ☐ No
    If 'yes', please explain.

20. Have you been told that your plantar fasciitis it related to your work duties? ☐ Yes ☐ No
    If 'yes', what is the name of the doctor who told you that your problem was related to your work duties?

Injured Worker's Name	Claim Number

21. What was the approximate date the doctor informed you of this?

22. What type of shoe gear do you normally wear at work?

23. What type of shoe gear do you normally wear outside of work?

24. .**Women:** Are you postmenopausal?
☐ Yes ☐ No
If yes, have you had any past menopausal symptoms or gynecological abnormalities?

25. Please provide any additional information or comments that may be helpful to us on the back of this page or on a separate sheet of paper.

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 - PENALTY FOR FILING FALSE CLAIMS
WITH WORKFORCE SAFETY & INSURANCE (WSI)

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.

I ACKNOWLEDGE, by my signature on this form, THAT I HAVE READ AND UNDERSTAND THE ABOVE DESCRIPTION OF THE PENALTIES FOR SUBMITTING A FALSE CLAIM FOR BENEFITS OR MAKING FALSE STATEMENTS TO WSI. I understand that WSI is relying upon the truth of my statements in awarding benefits or providing services on this claim. I CERTIFY THAT I HAVE NOT FILED A FALSE CLAIM, NOR MADE ANY FALSE STATEMENT, NOR KNOW OF ANY FALSE STATEMENT MADE IN CONNECTION WITH THIS CLAIM FOR BENEFITS WITH WSI.

Injured Worker's Signature	Date