



**PRIOR INJURY & PRE-EXISTING
CONDITION QUESTIONNAIRE**
CLAIMS DIVISION
SFN 51153 (11/2017)

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SECTION 1 – Worker's information				
Claim number	Worker's (First name)	(Last name)	Body part(s)	
SECTION 2 – Past medical treatment to claimed body area				
Before your current injury, have you ever had any problems, of any kind, in or around this area(s) of your body? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please answer the rest of the questions in this section on all claimed body areas. If no, skip to section 3.				
When did you have these previous problem(s)?				
Have you ever had an evaluation or treatment of this body area(s)? <input type="checkbox"/> Yes <input type="checkbox"/> No				
What was the diagnosis(es) of your past problem(s)?				
Please list any and all medical providers (Medical Doctor, Chiropractor, Physical Therapist, Massage Therapist, etc.) who have treated a problem(s) in this area(s) before this injury.				
Medical provider	City	State	Telephone number	
Before this injury, when did you last receive any treatment (physical therapy, chiropractor, medication, injection, etc.) for this problem(s)?				
How is your current problem different from the past problem?				
SECTION 3 – Past general medical treatment (Not related to claimed body area)				
Before this injury, have you missed more than a week from work due to any injury or pain problem? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please list pain problem, cause, year, duration of unemployment, and state of residence at the time.				
Pain problem	Cause	Year	Duration of unemployment	State of residence

Form is continued on next page. Please submit all pages to WSI.

PRIOR INJURY & PRE-EXISTING CONDITION QUESTIONNAIRE (cont'd)

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Claim number	Worker's (First name)	(Last name)
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Before this injury, have you ever received chiropractic treatment for any reason?

Yes No If yes, please list all past chiropractors

Chiropractor	City	State	Telephone number

Before this injury, have you received treatment (medical, physical therapy, chiropractic, medication, etc.) for any pain problem lasting more than one month?

Yes No If yes, please list diagnosis, year, and duration of treatment.

Diagnosis	Year	Duration of treatment

Please list names and location of all providers (medical, chiropractic, physical therapy, etc.) who have treated, provided evaluation, of treatment of a pain problem involving a body area not part of this injury claim (for example: spine pain, headache, joint pain, etc.) in the past 10 years.

Medical provider	City	State	Telephone number

Please identify the providers that have provided any routine medical care in the past.

Medical provider	City	State	Telephone number

Have you completed all above questions regarding all claimed body areas? Yes No

If yes, please initial.

If no, please explain why.

Have you ever filed any other workers compensation or personal injury claims, in any state, for injuries or health problems?

Yes No

If yes, in what state(s)

Name of insurance company?

When?

Type of injury?

PRIOR INJURY & PRE-EXISTING CONDITION QUESTIONNAIRE (cont'd)

SFN 51153 (12/2016)

Claim number	Worker's (First name)	(Last name)
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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?

Were you ever unable to work in the past due to injury or health problems? Yes No
 If yes, for how long?

In the past, has any doctor or medical provider told you to avoid certain physical activities because of an injury or health problems?
 Yes No If yes, complete the following

Restriction	Doctor who initiated restriction	Dates	
		From	To
		From	To
		From	To
		From	To

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 continues while I have any claim open or pending before WSI. 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 workers, 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.

Worker's Signature	Date
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