PRIOR INJURY & PRE-EXISTING CONDITION QUESTIONNAIRE

CLAIMS DIVISION
SFN 51153 (01/2015)

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Please print or type using black or blue ink.

Injured worker	Claim number	Body part (s)

1. Before your current injury, have you ever had any problems, of any kind, in or around this area(s) of your body?
   ☐ Yes ☐ No If yes, please be sure to answer questions 2-7 for all claimed body areas. If no, skip to question 8.

2. When did you have these prior problem(s)?

3. Have you ever had an evaluation or treatment of this body area(s)?
   ☐ Yes ☐ No

4. What was the diagnosis(es) of your past problem(s)?

5. 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) prior to this injury.

Medical provider	City	State	Telephone number

6. Prior to this injury, when did you last receive any treatment (physical therapy, chiropractor, medication, injection, etc.) for this problem(s)?

7. How is your current problem different from the past problem?

8. Prior to this injury, have you missed more than a week from work due to any injury or pain problem?
   ☐ Yes ☐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

9. Prior to this injury, have you ever received chiropractic treatment for any reason?
   ☐ Yes ☐ No If yes, please list all prior chiropractors

Chiropractor	City	State	Telephone number

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Claim Number	Injured Worker

10. Prior to 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

11. 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

12. Please identify the providers that have provided your routine medical care in the past 5 years.

Medical provider	City	State	Telephone number

13. Have you completed all above questions regarding all claimed body areas? ☐ Yes ☐ No
If yes, please initial.
If no, please explain why.

14. 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?

15. 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?

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

Claim Number	Injured Worker

17. 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

18. Please list the names and addresses of all medical providers that you see for your routine medical care.

Complete name	Address	City, State, ZIP code	Telephone number	Time frame

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.

Injured Worker's Signature	**Date**