North Dakota Workforce Safety & Insurance

FOOT AND ANKLE QUESTIONNAIRE

CLAIMS DIVISION
SFN 51817 (03/2024)

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SECTION 1 – *Injured employee's information*

Claim number	Injured employee's (First name)	(Last name)
Body part(s)		

SECTION 2 – *Current condition*

When did you first notice problems with your foot and/or ankle?

What were you doing when the problems occurred?

Describe your current job duties.

How much time per day is spent performing the described duties?

How long have you worked for your current employer?

How long have you done this type of work?

If you changed positions within the company, describe the physical activities of the prior position(s).

When did you become aware your condition was related to your work?

SECTION 3 – *Prior condition*

Have you ever injured your foot and/or ankle before?
☐ Yes ☐ No

If yes, how did the injury occur?

If yes, when did the injury occur?

If yes, where did you treat?

Have you ever treated previous symptoms on your own (Example: using a brace, exercise, orthotics, or over-the-counter medication)?
☐ Yes ☐ No

If yes, describe

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Claim number	Injured employee's (First name)	(Last name)

Have you been treated by an orthopedist or podiatrist (foot doctor)? ☐ Yes ☐ No
If yes, list the name(s) and addresses of medical provider(s) who treated you for these conditions.
Have you had x-rays, MRI's or CT scans of your feet or ankles? ☐ Yes ☐ No
If yes, list the date, where the imaging was done, and the results.
Do you have any congenital foot deformity since birth (Example: flat feet, high arches, etc)? ☐ Yes ☐ No
If yes, describe.
Have you been diagnosed with diabetes or arthritis? ☐ Yes ☐ No
If yes, describe.
Have you had recent trauma to your feet or ankles? ☐ Yes ☐ No
If yes, describe.
Do you participate in sports or hobbies outside of work? ☐ Yes ☐ No
If yes, list the sport or hobby and describe how often you do them.
Do you walk or run as part of an exercise program? ☐ Yes ☐ No
How much time per day is spent walking or running?
How much time per week is spent walking or running?
How far do you walk or run?
List exercise besides walking or running.
Have you been told your recent symptoms are related to your work duties? ☐ Yes ☐ No
If yes, list the name(s) and addresses of medical provider(s) who told you your recent symptoms are related to your work duties.

Claim number	Injured employee's (First name)	(Last name)

List the date the medical provider(s) told you your recent symptoms are related to your work duties.

What type of footwear do you normally wear at work?

What type of footwear do you normally wear outside of work?

Women: Are you post-menopausal?
☐ Yes ☐ No

SECTION 3 – *Release of information/fraud warning/signature*

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 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 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 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.

Injured employee's signature	**Date**