North Dakota Workforce Safety & Insurance

PRIOR INJURY & PRE-EXISTING CONDITION QUESTIONNAIRE

CLAIMS DIVISION
SFN 51153 (10/2019)

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SECTION 1 – *Injured employee's information*

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

SECTION 2 – *Past medical treatment to claimed body area(s)*

Have you ever had any previous problems or treatment, in or around the area(s) of your body listed above (work-related or non-work related)?
☐ Yes ☐ No

If yes, list the date(s) and name(s) and addresses of the medical provider(s).

Date	Name	Address

If yes, which body part(s)?

If yes, how did the injury or condition occur?

If yes, when did the injury or condition occur?

If yes, what did the medical provider tell you your diagnosis was (Example: fracture, sprain, dislocation, tendonitis, etc.)?

When did you last receive treatment (Example: office visit, injection, medication, etc.) or see a medical provider for this past problem, condition, or injury?

Have you ever had any diagnostic testing of any kind done on the above listed body part(s) (Example: MRI, CT scan, X-ray, EMG, Ultrasound, etc.)?
☐ Yes ☐ No

If yes, list the date(s) and the facility where the diagnostic testing was done and describe the results.

Date	Name	Address

Have you ever received chiropractic treatment (work-related or non-work related)?
☐ Yes ☐ No

If yes, list the date(s) and name(s) and addresses of the chiropractor(s).

Date	Name	Address

Have you ever received physical therapy/occupational therapy (work-related or non-work related)?
☐ Yes ☐ No

If yes, list the date(s), name(s), and addresses of the therapist(s).

Date	Name	Address

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

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

If yes, describe.

Explain if you feel your past problem, condition or injury is different from your current problem for which you are filing this claim.

SECTION 3 – *Past general medical treatment*

In the past, has any medical provider restricted you from performing certain physical activities at work or at home because of any injury, medical condition, or health problem(s); work-related or non-work related?
☐ Yes ☐ No

If yes, list restriction(s), medical provider(s) who initiated the restriction(s) and date(s).

List the names and addresses of all medical providers that you have seen for any of your routine medical care in the past.

Date	Name	Address

Have you ever filed a workers' compensation or personal injury claim, in any state, for any injuries or health problems?
☐ Yes ☐ No

If yes, in what state(s)?	Name of insurance company
When was the claim filed?	Type of injury?

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?

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 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.

Employee's signature	**Date**

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