WSI
North Dakota Workforce Safety & Insurance

REPETITIVE MOTION QUESTIONNAIRE

CLAIMS DIVISION
SFN 50306 (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*

What is your dominant hand?
☐ Right ☐ Left ☐ Ambidextrous (both)

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

Describe the motion/movements of your shoulder(s), arm(s), wrist(s), hand(s), elbow(s), or affected body part(s) required by your current job (including computer usage).

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

How much time per week is spent performing the described movements?

How long have you done this type of work?

How long have you worked for your current employer?

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

How long were you in the prior position(s)?

When did you start your current position?

If employed with your current employer less than 1 year, provide the following information

Previous employer(s)	Length of employment	Description of position

Do you work more than 1 job or own a home-based business?
☐ Yes ☐ No

If yes, list the name, address, and telephone number of the employer(s)/home-based business.

How long have you worked for the other employer(s) or owned the home-based business?

Describe the motion/movements of your shoulder(s), arm(s), wrist(s), hand(s), elbow(s), or affected body part(s) required by these jobs (including computer usage).

Do you operate machinery or tools that vibrate?
☐ Yes ☐ No

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

Do you farm or ranch? ☐ Yes ☐ No
Do you have any hobbies (Example: knitting, gardening, canning, playing musical instruments, mechanical work, etc.)? ☐ Yes ☐ No
If yes, list the hobbies and describe how often you do them.
How many hours per day do you play video or computer games?
How many hours per day do you use your home computer?
How many hours per day do you use your cell phone or tablet?
How many texts do you send per day?
Have you or do you participate in any sports (Example: fishing, bowling, weightlifting, darts, etc.)? ☐ Yes ☐ No
If yes, list the sport(s) and describe how often you do them.
Do you participate in a regular exercise program? ☐ Yes ☐ No
If yes, describe the activities and how often you do them.
SECTION 3 – *Prior condition*
Have you ever injured your shoulder(s), arm(s), wrist(s), hand(s), elbow(s), or affected body part(s) (Example: fractured, sprained, or dislocated) before? ☐ Yes ☐ No
If yes, which body part(s)?
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, or over-the-counter medication)? ☐ Yes ☐ No
If yes, describe.
Do you experience any pain when bending your hand(s) forward? ☐ Yes ☐ No
If yes, describe.

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

Do you experience any pain when bending your hand(s) backward?
☐ Yes ☐ No

If yes, describe.

Have you ever had an Electromyography (EMG)/Nerve Conduction test?
☐ Yes ☐ No

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

Have you ever had x-rays, MRIs, or CT scans, or surgeries of your shoulder(s), arm(s), wrist(s), hand(s), elbow(s), or affected body part(s)?
☐ Yes ☐ No

If yes, list the date(s), where the imaging/surgery was done, and describe the results (Example: fracture, sprain, arthritis, etc.).

Have you been diagnosed as having, or possibly having, diabetes, kidney disease, liver disorder, thyroid disease, neurological disorder, or alcoholism?
☐ Yes ☐ No

If yes, describe.

If yes, list the name(s) and addresses of all medical providers who have treated you for these conditions.

Have you had neck problems or injuries?
☐ Yes ☐ No

If yes, list the date(s), name(s) and addresses of all medical providers who have treated you for this condition.

Have you been involved in an automobile accident?
☐ Yes ☐ No

If yes, list the body part(s) injured and when the automobile accident occurred.

Did you seek medical treatment after the automobile accident?
☐ Yes ☐ No

If yes, list the name(s) and addresses of all medical providers who treated you for the automobile accident injury.

Have you been told the current condition in your shoulder(s), arm(s), wrist(s), hand(s), elbow(s), or affected body part(s) is related to your work duties?
☐ Yes ☐ No

If yes, list the date and name of the medical provider who told you that your current condition is related to you work duties.

SECTION 4 – *Women's questions*

Have you had gynecological abnormalities?	Have you taken oral contraceptives or similar hormones?
☐ Yes ☐ No	☐ Yes ☐ No

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

Are you or have you been pregnant? ☐ Yes ☐ No	If yes, when was your last pregnancy?

SECTION 5 – *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 this authorization may be revoked at any time in writing. Revocation of this authorization will not apply to any information released prior to receipt of my written revocation of this authorization.

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**

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