



BACK PAIN QUESTIONNAIRE

To be completed by the Proposed Insured.

Name of Applicant \_\_\_\_\_ Date of Birth \_\_\_\_\_

Group Name \_\_\_\_\_ Group # \_\_\_\_\_ Member # \_\_\_\_\_

Please provide the following information if you ever had an episode of back or neck pain or disorder or injury of the spine.

1. What diagnosis was given by the doctor? \_\_\_\_\_ Date: \_\_\_\_\_

2. How often are you seen by the doctor? \_\_\_\_\_

3. Any known disc disorder?  Yes  No

4. What area(s) of the back are affected? \_\_\_\_\_

Provide treatment details. \_\_\_\_\_

5. Has future surgery ever been discussed or recommended?  Yes  No

If "Yes", please explain. \_\_\_\_\_

\_\_\_\_\_
\_\_\_\_\_
\_\_\_\_\_

6. Have you ever consulted a chiropractor?  Yes  No If "Yes", indicate date of last visit. \_\_\_\_\_

Indicate frequency of treatment. \_\_\_\_\_

7. Do you take any medication?  Yes  No

If "Yes", please list all medications, including the daily dosage or date last used. \_\_\_\_\_

\_\_\_\_\_
8. Does your job involve lifting or carrying?  Yes  No If "Yes", indicate the frequency and approximate weight of objects being lifted. \_\_\_\_\_

9. Have you ever been disabled or lost work time due to a back problem?  Yes  No

If "Yes", please provide dates and diagnosis. \_\_\_\_\_

\_\_\_\_\_
10. Was your injury a Workers Compensation Claim?  Yes  No If "Yes", please provide the name and telephone number of the company processing the claim and/or the name and telephone number of the underwriter. \_\_\_\_\_

\_\_\_\_\_

11. Has there been a complete recovery?  Yes  No If "No", please indicate current symptoms and indicate any restrictions of treatment (e.g. weight lifting limit, required therapy, use of TENS machine, etc.).

\_\_\_\_\_

\_\_\_\_\_

I represent to the best of my knowledge and belief that each of the above statements and answers are complete and true. I understand that the answers to the above questions will be the basis of any coverage issued and that any incorrect answers may operate to void this insurance.

Signature of Proposed Insured \_\_\_\_\_ Date \_\_\_\_\_