BACK PAIN QUESTIONNAIRE

Reset Form

Name	Date of Birth (dd/mmm/yy)	Application #

1. Location of back pain: ❍ Cervical (neck) ❍ Thoracic (mid back) ❍ Lumbar (low back)

When did the first symptom occur? (dd/mmm/yy)

What appeared to be the reason for your symptoms?

How often do symptoms occur and how long do they last?

Do you have any radiation? ❍ Yes ❍ No If yes, please state where:

Have you had any recurrence? ❍ Yes ❍ No If yes, please state date(s), treatment(s) and length of time for each:

Are you currently experiencing any symptoms? ❍ Yes ❍ No If no, how long have you been symptom free?
If yes, describe current symptoms:

Date & results of last x/ray, MRI or CT scan: ❍ never had one

Do you have any tests pending? ❍ Yes ❍ No If yes, please state test & scheduled date:

Name address & phone number of medical advisor(s) consulted:

Details of any medication taken (type, dose, frequency):	Still taking medication	Date medication was stopped
	❍ Yes ❍ No	
	❍ Yes ❍ No	
	❍ Yes ❍ No	
	❍ Yes ❍ No	

2. Have you ever had:
❍ Physiotherapy ❍ Chiropractic adjustments ❍ Exercise

Have you ever been hospitalized for this condition? ❍ Yes ❍ No If yes, please give details below

Have you ever had or do you anticipate surgery for this condition? ❍ Yes ❍ No If yes, please give details below

Have your job duties or leisure activities been affected in any way or have you lost any time from work because of your condition?
❍ Yes ❍ No If yes, please give details:

I hereby declare that the above answers are complete and true, and agree that they shall form part of my application for the policy requested.

Signature of Applicant	Signature of Witness	Date (dd/mmm/yy)
X	X	

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