

BACK PAIN AND MUSCULOSKELETAL QUESTIONNAIRE

PROPOSED INSURED _____ DATE OF BIRTH / /
MM DD YYYY

1. Please state the precise diagnosis, or nature of the disorder e.g. simple back or neck strain, degenerative disk disease, herniated disk, lumbago, sciatica, spondylosis, whiplash, carpal tunnel disease, separated shoulder, etc:

2. When did you first experience symptoms? _____
 - a. Are your symptoms ongoing? Yes No
 - b. If YES, describe ongoing symptoms/limitations? _____
 - c. Have you claimed benefits from any source in relation to this condition? Yes No
If YES, please provide details: _____
 - d. If you are no longer experiencing symptoms, when did they last occur? _____
3. Please describe details of any treatment that you have had for this condition, e.g. arthroscopy, other surgery, treatment by physiotherapist, massage therapist, acupuncturist, naturopath etc.

4. Have you ever taken off work for this condition? Yes No
If YES, for how long: _____
5. Have your working duties been affected or restricted in any way? Yes No
If YES, explain: _____

ADDITIONAL INFORMATION REQUIRED FOR BACK CONDITIONS ONLY

6. What area(s) of the back was involved? (Circle): NECK (Cervical) MIDDLE BACK (Thoracic) LOW BACK (Lumbosacral)
Was the problem caused by: DISC MUSCULAR BONES NERVE CONGENITAL
7. Have you ever been diagnosed with a spinal disc herniations? Yes No
If YES, specify: CERVICAL THORACIC LUMBAR
8. Did the pain radiate? Yes No
If so, where: _____
9. Names and addresses of all doctors, chiropractors or other practitioners consulted. Also provide names of hospitals or clinics that you have attended: (Please also indicate dates.)

10. In the past 10 years have you:
 - a. Undergone any x-rays or other investigations of the back? Yes No
 - b. Had or been advised to have treatment or surgery for back complaint? Yes No
 - c. Been disabled or unable to perform your regular duties due to back complaint? Yes No
 - d. Had any restrictions of movement of your back? Yes No
 If YES to above, provide details: _____

11. How long have you been free of back symptoms, in all forms? _____
12. Are you currently receiving, or within the past 12 months have you received, preventative maintenance? Yes No
If YES, how often? _____

I understand that this questionnaire will form part of the application for insurance I have made to La Capitale Financial Security Insurance Company. I certify that the answers are true and complete.



Signature of Proposed Insured

Date