

BACK DISORDER/PROBLEMS QUESTIONNAIRE

Name of person completing questionnaire:		Date:
Applicant's Name:		Date of Birth:
Social Security Number:	Height:	Weight:
Last Doctor's visit:	Any surgeries: <input type="checkbox"/> Yes <input type="checkbox"/> No	Chiropractor: <input type="checkbox"/> Yes <input type="checkbox"/> No
Have you ever been hospitalized? <input type="checkbox"/> Yes <input type="checkbox"/> No Date(s):		Counseling: <input type="checkbox"/> Yes <input type="checkbox"/> No
Any auto/work related injuries? <input type="checkbox"/> Yes <input type="checkbox"/> No	Any other medical conditions or medications? <input type="checkbox"/> Yes <input type="checkbox"/> No	

- When first diagnosed? _____
- Cause? _____
- Problems with nerves, muscles, disc, etc. _____
- Which area(s) affected (neck, back-upper/middle/lower)? _____
- Type of treatment? _____
 Physical therapy, injections, etc. _____
 Current treatment: _____
 How often? _____
- Current medications – names, milligrams (pill or shot): _____
 How often is medication taken? _____
- Did you see a Doctor or Chiropractor? _____
 How often? _____
- Any surgery? Yes No
 When? _____
 Type of surgery? _____
 What area was operated on? _____
 Inpatient Outpatient
- Any disability or deformity? Yes No
- Any problems since the surgery? Yes No
- Future surgery, treatments or testing planned? Yes No If yes, explain. _____
- When was the last Doctor visit for this condition: _____
 Doctor's name and address: _____
- If due to an injury, is any other insurance carrier paying the claims? Yes No

Notes: _____

To the best of my knowledge, all statements and answers on this questionnaire are complete and true. If any information should result as false or inaccurate, I understand my coverage will be terminated at any time.

 Signature

 Date