

BACK OR NECK PAIN QUESTIONNAIRE

NAME OF APPLICANT: _____ DATE OF BIRTH: _____

POLICY #: _____ REFERENCE #: _____

1 Have you ever had pain or discomfort in your back? Yes No Neck? Yes No

If so, (a) How many times? _____

(b) Date of first episode. _____

(c) Date of last episode. _____

(d) Longest duration of discomfort _____

2 (a) What area of the back was involved? Select one:

Neck (cervical) Middle (thoracic) Low (lumbo sacral)

(b) Does the pain radiate? Yes No

Where? _____

(c) Give diagnosis: _____

3 (a) Was this the result of an injury? Yes No

(b) Give details: _____

4 Have you:

(a) undergone any x-rays or other investigation of your back or neck? Yes No

Details: _____

(b) ever had or been advised to have treatment or surgery for any back or neck complaint? Yes No

Details: _____

(c) ever had or do you now have chiropractic treatment for your back or neck? Yes No

Details: _____

(d) ever been hospitalized for any back or neck complaint? Yes No

Details: _____

(e) ever been disabled or unable to work because of back or neck discomfort? Yes No

Details: _____

(f) any restriction of movement of your back or neck at present? Yes No

Details: _____

(SEE OVER)

