

Back Pain Questionnaire			
First Name :Policy Number :			
1.	Have you ever experienced pain or discomfort in your bac If yes, please provide details by answering the following q		□Yes □No
2.	Please indicate which of the following apply to your condition, and provide us with further details :		
	Symptoms ☐ Neck pain (cervical) ☐ Middle of back pain (thoracic) ☐ Low back pain (lumbar) ☐ Pain radiating to the arm(s) ☐ Pain radiating to the leg(s) ☐ Other: ☐ Tests ☐ Back X-rays ☐ CAT scan	Details (dates and duration) Details (dates and results)	
	☐ MRI ☐ Other: Treatment / Surgery ☐ Medication	Details (dates and duration)	
	☐ Physiotherapy ☐ Chirotherapy ☐ Massage therapy ☐ Acupuncture ☐ Surgery ☐ Other:		
3.	Date you first experienced symptoms :		
4.	Frequency of symptoms :		
5.	Date of your last symptoms :		
6.	Was any hospitalization required for your back condition? If yes, dates and duration:		☐Yes ☐No
7.	Was any time off work required for your back condition? If yes, dates and duration:		□Yes □No
8.	Do you have any pending consultation, treatment or surgery? If yes, please provide details (date, treatment, name of physician)		☐Yes ☐No
9.	Do you currently have any restrictions of movement in your back?		□Yes □No
	that the above information is true and complete and acknowledge of proposed insured (parent or legal guardian if a minor)		