Assumption Life

Reset

Back Pain Questionnaire

First Name : _____ Last Name : _____

Policy Number : _____ Date of Birth (DD/MM/YYYY): ____/____/_____

1. Have you ever experienced pain or discomfort in your back or neck? ☐ Yes ☐ No
   If yes, please provide details by answering the following questions:

2. Please indicate which of the following apply to your condition, and provide us with further details :

Symptoms	**Details (dates and duration)**
☐ 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	**Details (dates and results)**
☐ Back X-rays	_____
☐ CAT scan	_____
☐ MRI	_____
☐ Other : _____	_____

Treatment / Surgery	**Details (dates and duration)**
☐ Medication	_____
☐ 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? ☐ Yes ☐ No
   If yes, dates and duration: _____

7. Was any time off work required for your back condition? ☐ Yes ☐ No
   If yes, dates and duration: _____

8. Do you have any pending consultation, treatment or surgery? ☐ Yes ☐ No
   If yes, please provide details (date, treatment, name of physician). _____
   _____

9. Do you currently have any restrictions of movement in your back? ☐ Yes ☐ No

I declare that the above information is true and complete and acknowledge that it shall form part of my insurance application with Assumption Life.

_____ _____

Signature of proposed insured (parent or legal guardian if a minor) Date (DD/MM/YYYY)

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
P.O. Box 160/770 Main St., Moncton NB E1C 8L1 Tel. 506-853-6040/1-800-455-7337 Fax 855-230-2500