Assumption Life

Reset

Musculoskeletal Disorder Questionnaire

First Name _____ Last Name _____

Application or Policy Number _____ Date of Birth _____

Have you ever experienced musculoskeletal pain or discomfort? ☐ Yes ☐ No

If yes, please provide details by answering the following questions:

1. Please indicate which joint(s) or areas of the body are/were affected. _____
   _____
2. What was the underlying cause (e.g. accident, degeneration, recreational or sporting injury, etc.)? _____
   _____
3. Date you first experienced symptoms _____
4. Please describe your symptoms _____
   _____
5. Frequency of symptoms _____
6. Date of your last symptoms _____
7. Was this musculoskeletal pain or discomfort a first-time occurrence or have you experienced it in the past? Please describe. _____
   _____
8. Please indicate which of the following apply to your condition, and provide us with further details:

Tests/Treatments	**Details (dates, duration and results)**
☐ Name of medication	_____
☐ X-rays	_____
☐ CAT scan	_____
☐ MRI	_____
☐ Physiotherapy	_____
☐ Chirotherapy	_____
☐ Massage therapy	_____
☐ Acupuncture	_____
☐ Surgery	_____
☐ Other:_____	_____

9. Was any hospitalization required for your musculoskeletal condition? ☐ Yes ☐ No
   If yes, dates and duration _____
10. Was any time off work required due to your musculoskeletal pain or discomfort? ☐ Yes ☐ No
    If yes, dates and duration _____
11. Do you have any pending consultation, treatment or surgery? ☐ Yes ☐ No
    If yes, please provide details (date, treatment, name of attending physician). _____
12. Do you currently have any musculoskeletal restrictions in your movements? ☐ Yes ☐ No
    If yes, please provide details. _____

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 the person to be insured (parent or legal guardian if a minor) Date

Assumption Mutual Life Insurance Company, doing business under the name Assumption Life,
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