

## Musculoskeletal Disorder Questionnaire

First Name \_\_\_\_\_  
 Application or Policy Number \_\_\_\_\_

Last Name \_\_\_\_\_  
 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)**

- |                                             |       |
|---------------------------------------------|-------|
| <input type="checkbox"/> Name of medication | _____ |
| <input type="checkbox"/> X-rays             | _____ |
| <input type="checkbox"/> CAT scan           | _____ |
| <input type="checkbox"/> MRI                | _____ |
| <input type="checkbox"/> Physiotherapy      | _____ |
| <input type="checkbox"/> Chirotherapy       | _____ |
| <input type="checkbox"/> Massage therapy    | _____ |
| <input type="checkbox"/> Acupuncture        | _____ |
| <input type="checkbox"/> Surgery            | _____ |
| <input type="checkbox"/> 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 \_\_\_\_\_