



FOLLOW UP QUESTIONNAIRE: BACK PAIN

Employee Name _____ **Group Name** _____
Proposed Insured _____ **D.O.B.** _____

1. Have you ever had any type of spinal disorder or episodes of back and/or neck pain?
Yes___ No___
2. Do you have any known disc disorder? Yes___ No___
3. Please list affected area of back, dates of treatment and your doctor's name, address, and phone number.
4. What diagnosis did your doctor give you?
5. Did your doctor ever mention or discuss back surgery? (Y/N)____
If yes, please explain.
6. Has your back trouble ever caused you to miss work or be disabled?
7. Have you ever collected Worker's Compensation or disability insurance?
If so, please list the dates you received this and the type of condition.
8. Have you ever consulted a chiropractor? (Y/N)____ *If yes, please list the doctor's name, address, and phone number*
9. Do you regularly take any medication? (Y/N)____ *If yes, please list the medication and daily dosage.*
10. Does your job involve any lifting or carrying? (Y/N)____ *If yes, please specify the amount and weight of the objects.*
11. Have you had a complete recovery? (Y/N)____ *If yes, please list your current health status.*
12. Do you smoke? If yes, how many cigarettes per day?

I represent to the best of my knowledge and belief that each of the above statements and answers are complete and true. I understand that the answers to the above questions will be the basis of any coverage issued and that any incorrect answers may operate to void this insurance.

Date: _____ **Signature of proposed insured:** _____

Use reverse side for additional comments or if further space is required.