

NAME			
FIRST NAME			
DATE OF BIRTH			APPLICATION OR POLICY NUMBER
D	M	Y	

## BACK PAIN QUESTIONNAIRE

1. Date of first back pain episode: \_\_\_\_\_
2. Have you had more than one episode: Yes  No   
If yes, provide complete details: \_\_\_\_\_
3. Which activities tend to induce pain? \_\_\_\_\_
4. How frequently do symptoms occur? \_\_\_\_\_
5. Name of the doctor(s) consulted and date(s): \_\_\_\_\_
6. Diagnosis: \_\_\_\_\_
7. Have you undergone any investigations on your back? Yes  No   
If yes, provide full details and final results: \_\_\_\_\_
8. Have you had medications prescribed:  Yes  No  
If yes, please complete the following table:

Name of medication	Dosage	Frequency	Date of last used

9. Have you ever had any chiropractic treatments, physiotherapy, osteopathy, etc.? Yes  No   
If yes, please complete the following table:

Type of treatment	Name of practitioner or clinic	Address	Frequency	Date of last consultation

10. Have you or ever had any restriction of your activities because of the discomfort? Yes  No   
If yes, provide complete details: \_\_\_\_\_
11. Have you ever been disabled or unable to work because of back discomfort? Yes  No   
Date: From \_\_\_/\_\_\_/\_\_\_ To \_\_\_/\_\_\_/\_\_\_ More than once Date: From \_\_\_/\_\_\_/\_\_\_ To \_\_\_/\_\_\_/\_\_\_
12. Are you completely free of back symptoms? Yes  No   
If no, provide complete details: \_\_\_\_\_
13. Have you had any recurrence of symptoms? Yes  No   
If yes please provide details: \_\_\_\_\_
14. Do you have any sequel or side effects? \_\_\_\_\_

I declare that all statements and answers provided above are complete and true and that the information shall form part of my insurance application with **UL Mutual**.

X _____ SIGNATURE OF THE PROPOSED INSURED	X _____ SIGNATURE OF THE POLICY OWNER
X _____ WITNESS	_____ DATE