HUMANIA ASSURANCE MD®

Back pain Questionnaire

Identification

Policy number:

Name of person to be insured:

First Name of person to be insured:

Date of birth: year / month / day

Section Back pain

1. Have you ever experienced any back or neck pain? ☐ Yes ☐ No

Date of first episode: year / month / day

Date of last episode: year / month / day

Frequency of episodes: ______ time per week ______ time per month ______ time per year

Average duration of each episode (in days): ______

a) Where was the pain located?

☐ Neck (cervical) ☐ Center (thoracic) ☐ Lower back (lumbar or lumbosacral)

b) Does the pain radiate to other parts of the body? ☐ Yes ☐ No

If yes, where? ______

c) Did you have any X-Rays or other tests(Scans, Magnetic Resonance Imaging, etc)? ☐ Yes ☐ No

If yes, what type of tests were completed: ______

What was the result(s): ______

d) What was the diagnostic (or diagnostics, if more than one episode)? ______

e) What was treatment(s) prescribed? ______

2. Are you currently taking medication? ☐ Yes ☐ No

If yes, name of the medication(s)? ______

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Back pain (...continued)

3. Have you been unable to work because of neck or back pain? ☐ Yes ☐ No

If yes, date you stopped working: ____ / __ / __ (year / month / day) Date you returned to work: ____ / __ / __ (year / month / day)

If more than one episode of time lost from work, please indicate the dates you stopped working and returned to work for each episode:

4. Have you ever been hospitalized due to back or neck pain? ☐ Yes ☐ No

If yes, indicate the name and address of the hospital:

First date of hospitalization: ____ / __ / __ (year / month / day) Last date of hospitalization: ____ / __ / __ (year / month / day)

5. Have you undergone back surgery because of your back or neck pain? ☐ Yes ☐ No

If yes, what type of surgery was completed?

Name and address of the physician and health care facility where the surgery was completed:

6. Have you been advised to undergo surgery due to your back or neck pain? ☐ Yes ☐ No

If yes, what type of surgery was recommended?

If the surgery is pending, indicate the approximate date it will take place: ____ / __ / __ (year / month / day)

Name and address of the physician and health care facility that the surgery will take place:

7. Have you had any steroid epidural injections or had treatment in a pain management clinic?

☐ Yes ☐ No

Dates of consultation: ____ / __ / __ (year / month / day) ____ / __ / __ (year / month / day) ____ / __ / __ (year / month / day)

Name and address of the physician of the clinic consulted:

douleurs dans le dos (suite)

8. Have you ever been treated by a chiropractor, physiotherapist, kinesiotherapist or another specialist for your back or neck pain?

☐ Yes ☐ No

If yes, indicate the name and address of the health practionners and health care facilities consulted:

What area of your back was treated?

☐ Neck (cervical) ☐ Center (thoracic) ☐ Lower back (lumbar or lumbosacral)

Date of first visit: year / month / day Date of last visit: year / month / day

Frequency of visits: ____ per week ____ per month ____ per year

Duration of treatments:

Approximately, how many visits since your initial visit:

9. Have your professional duties or daily activities been modified or restricted because of your back or neck problem?

☐ Yes ☐ No

If yes, indicate the restrictions, limitations or modifications:

10. Do your symptoms persist? ☐ Yes ☐ No

If yes, please specify:

11. Provide names and addresses of all physicians, clinics or health practitioners consulted, including dates of consultation, not previously mentionned:

12. Provide any additional pertinent information or comments not previously disclosed related to back or neck pain. Use a separate sheet if necessary:

I, the undersigned, declare that the above answers are true and complete and shall form part of my application for insurance with Humania Assurance

Signature of the person to be insured:

Signature of witness:

Date: Signed at: year / month / day