QUESTIONNAIRE:
Back Health Prequalification

Please complete the following questions with as many details as possible.
In this supplement, "you" and "your" mean the Proposed Insured.

Name of Proposed Insured: ____ DOB _______________

Gender: ☐ M ☐ F Do you use Tobacco? ☐ Yes ☐ No

1. In the last 10 years, have you had any symptoms, complaints, disorders, medical consultations, or treatments concerning any of the following regions of the back? If you answer yes, insert dates of first and last symptoms.

Upper (neck/cervical region) ☐ Yes ☐ No Dates: _____________________________________

Middle (thoracic region) ☐ Yes ☐ No Dates: _____________________________________

Lower (lumbosacral region) ☐ Yes ☐ No Dates: _____________________________________

2. Describe your symptoms and reasons for medical consultations: _____________________________________

____

____

3. Name and address of physicians, chiropractors, or other therapists and month/year each was last seen:

____

____

4. Have you ever had surgery for any of these conditions: ☐ Yes ☐ No
If yes, give dates, reasons and name and address of hospital or facility: ________________________________

____

5. Describe other type(s) of treatment received (manipulation, heat, physical therapy): ____________________

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6. Has treatment included the use of prescription medications? ☐ Yes ☐ No List medications and start/stop dates:

____

7. Name prescribing physician (include address) if not shown in item 3 above:

____

8. Have you missed work more than 4 consecutive work days for any of the above conditions? ☐ Yes ☐ No

If yes, give dates and details: ____

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