

**BACK/ JOINT QUESTIONNAIRE**

1. **INSURED'S NAME** \_\_\_\_\_ **APPLICATION NUMBER** \_\_\_\_\_
2. **LOCATION OF INJURY?** \_\_\_\_\_  
(back, knee, left, right, etc?)
3. **WHAT WAS DOCTOR'S DIAGNOSIS?** \_\_\_\_\_  
(IE: strain, sprain, muscle pull, pinched nerve, ruptured disc, etc?)
4. **DATE OF INJURY** \_\_\_\_\_
5. **HOW LONG OFF WORK?** \_\_\_\_\_
6. **HOSPITALIZED?** \_\_\_\_\_ **DATE?** \_\_\_\_\_ **DURATION?** \_\_\_\_\_  
**NAME OF HOSPITAL?** \_\_\_\_\_
7. **ANY SURGERY ?** \_\_\_\_\_ **DATE?** \_\_\_\_\_
8. **ANY PAIN, PROBLEMS OR MEDICATION SINCE THEN?** \_\_\_\_\_  
**IF YES, DATE & EXPLANATION?** \_\_\_\_\_  
\_\_\_\_\_
9. **NAME/ADDRESS OF DOCTOR WITH MOST RECENT RECORDS OF INJURY?** \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
10. **ARE YOU CURRENTLY DISABLED DUE TO THIS INJURY?** \_\_\_\_\_
11. **HAVE YOU EVER DISABLED DUE TO THIS INJURY?** \_\_\_\_\_  
**IF YES, PLEASE GIVE DETAILS AND DATES:** \_\_\_\_\_  
**(FOR BACKS ONLY:)**
12. **ARE YOU TREATED BY A CHIROPRACTOR?** \_\_\_\_\_ **LAST SEEN?** \_\_\_\_\_  
**NAME/ADDRESS?** \_\_\_\_\_  
\_\_\_\_\_

X \_\_\_\_\_  
Proposed Insured's Signature

DATE \_\_\_\_\_

X \_\_\_\_\_  
(Agent's Signature)

