

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) _____



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, kinesiologist or another specialist for your back or neck pain?

Yes No

If yes, indicate the name and address of the health practitioners 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 mentioned:

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