

**SPINAL – BACK – CHIRO QUESTIONNAIRE**

Please answer all questions pertaining to the person for which the condition applies. If you need assistance in completing this form, please contact your physician. If you need more space, please turn this sheet over and continue.

Name of primary applicant: \_\_\_\_\_ ID/SSN: \_\_\_\_\_

Name of person treated/relationship to applicant: \_\_\_\_\_

1. Have you ever had pain in your back, neck or shoulder? \_\_\_yes \_\_\_no If yes,
  - a. How many times?(#) \_\_\_\_\_
  - b. Date of first episode \_\_\_\_\_
  - c. Date of last episode \_\_\_\_\_
2. What area(s) involved? \_\_\_neck (cervical) \_\_\_middle (thoracic) \_\_\_low (lumbosacral)
  - a. Does the pain radiate? \_\_\_yes \_\_\_no If yes, where? \_\_\_\_\_
  - b. Give definitive diagnosis, if known \_\_\_\_\_
3. Is this a disc disorder? \_\_\_Yes \_\_\_No If yes, indicate type: \_\_\_ Herniation \_\_\_ Rupture \_\_\_ Protrusion
4. Was this the result of an injury? \_\_\_ yes \_\_\_ no  
If yes, give details \_\_\_\_\_

5. Have you ever been diagnosed with Scoliosis? \_\_\_ yes \_\_\_ no If yes, degree of curvature \_\_\_\_\_
6. Due to back pain, have you, taken prescription medication? \_\_\_yes \_\_\_no  
If yes, list your medication(s):

| Name of Medication | Dosage | Frequency |
|--------------------|--------|-----------|
|                    |        |           |
|                    |        |           |

7. Have you ever had or been advised to have surgery / or spinal fusion? \_\_\_yes \_\_\_no. If yes, give details: \_\_\_\_\_

8. Have you ever had or now have chiropractic treatment for your back? \_\_\_yes \_\_\_no

How often? \_\_\_\_\_ Date last seen? \_\_\_\_\_

9. Have you ever had loss of time at work or restriction of activities? \_\_\_yes \_\_\_no

If yes, how long were you off work? \_\_\_\_\_

When did you return to work? \_\_\_\_\_

10. What is the current status of your back, neck or shoulder pain? \_\_\_\_\_

11. Name and address of treating physician:

| Name of Physician | Address | Telephone Number |
|-------------------|---------|------------------|
|                   |         |                  |

Date last seen: \_\_\_\_\_

It is understood and agreed that the foregoing answers are true and shall be an attachment to my application for insurance and shall be the basis for the issuance of the Membership Certificate applied for, and that the omission or misstatement of any material information in answer to the foregoing questions shall void the membership certificate.

| Signature of person treated (or parent / guardian if under 18) | Date |
|--|------|
|  |      |