

## Neck and back pain questionnaire

(by insured life)

Policy number

Member number\*

Group number\* (\*Fill in for FundsAtWork)

### 1: Details of insured life

Name of insured life	<input type="text"/>		
Permanent identity/passport number	<input type="text"/>	Permanent identity number	Yes <input type="checkbox"/> No <input type="checkbox"/>
Date of birth	<input type="text"/>	Telephone	<input type="text"/>
Financial adviser's name	<input type="text"/>		
Broker house code	<input type="text"/>	Financial adviser code	<input type="text"/>
		Telephone	<input type="text"/>

### 2: General questions

1. When did you first experience neck or back pain?

1st symptoms	Last symptoms	Continuous symptoms
Event 1 <input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

2. Was this

A single event <input type="checkbox"/>	One of multiple events* <input type="checkbox"/>
---	--

\*For multiple events, complete all relevant dates

1st symptoms	Last symptoms	Continuous symptoms
Event 2 <input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Event 3 <input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Event 4 <input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>
Event 5 <input type="text"/>	<input type="text"/>	Yes <input type="checkbox"/> No <input type="checkbox"/>

3. If this was a single event, provide full details:

4. What is or was the cause of the neck or back ailment?

Injury <input type="checkbox"/>	Illness <input type="checkbox"/>	Since birth <input type="checkbox"/>	Other <input type="checkbox"/>
---------------------------------	----------------------------------	--------------------------------------	--------------------------------

If "other", provide full details:

5. What is or was the nature of the condition that causes/caused the symptoms?

Fracture <input type="checkbox"/>	Slipped/Narrowed disk <input type="checkbox"/>	Muscle injury <input type="checkbox"/>	Ligament injury <input type="checkbox"/>
Curvature of the spine (scoliosis) <input type="checkbox"/>	Arthritis <input type="checkbox"/>	Other <input type="checkbox"/>	

Provide full details, including dates:

6. Which part of the spinal column is or was affected?

Neck (cervical) <input type="checkbox"/>	Lower back (lumbar) <input type="checkbox"/>	Chest (thoracic) <input type="checkbox"/>	Lumbosacral <input type="checkbox"/>
--	--	---	--------------------------------------

Provide full details, including dates:

7. Do you currently experience or do you have a history of any of the following "chronic pain conditions"?

Chronic headache (migraine, tension headache) <input type="checkbox"/>	Joint pains, other than the back <input type="checkbox"/>
Muscular pains (fibromyalgia) <input type="checkbox"/>	Spastic colon syndrome <input type="checkbox"/>
Other, specify <input type="text"/>	

Provide full details, including dates:

8. Do you suffer from chronic fatigue syndrome (yuppie flu) at present or did you suffer from it in the past?

Yes <input type="checkbox"/>	No <input type="checkbox"/>
------------------------------	-----------------------------

If "yes", provide full details, including dates:

## 2: General questions (continued)

9. Do you have any symptoms of depression or job-related stress at present or have you had them in the past? Yes  No

If "yes", provide full details, including dates:

1st date	2nd date	3rd date
M M Y Y Y Y	M M Y Y Y Y	M M Y Y Y Y

10. Do you receive treatment for depression or job-related stress at present or have you received treatment for it in the past? Yes  No

If "yes", provide full details, including dates:

1st date	2nd date	3rd date
M M Y Y Y Y	M M Y Y Y Y	M M Y Y Y Y

11. Are you consulting a psychologist or psychiatrist at present or have you done so in the past? Yes  No

If "yes", provide full details, including dates:

12. Have you experienced any functional impairment as a result of this neck and back pain? Yes  No

If "yes", to what degree does it limit your occupational activities at present or did it limit these activities in the past?

13. Have you ever been absent from work as a result of this neck and back problems? Yes  No

If "yes", provide full details, including dates:

14. Have you undergone any of the following special examinations? Yes  No

X-rays	CT scans	MRI scans	Other
M M Y Y Y Y	M M Y Y Y Y	M M Y Y Y Y	M M Y Y Y Y

Date of special examinations

Result of special examinations

If 'other', provide full detail including results and dates:

15. What treatment was or is being given?

Physiotherapy	M M Y Y Y Y	Manipulation	M M Y Y Y Y
Fusion	M M Y Y Y Y	Bed rest	M M Y Y Y Y
Traction	M M Y Y Y Y	Medication	M M Y Y Y Y
Other	M M Y Y Y Y		

Provide full details (if medication, state brand name):

16. Are there or have there been any other symptoms or illnesses associated with your ailment? Yes  No

If "yes", provide full details:

17. Provide any further details, including referrals to, consultations with or treatment received from the following medical professionals. (Provide the full names and addresses, as well as the dates.):

Orthopaedic surgeons	Neurosurgeons	Physiotherapists	Chiropractors
Osteopaths	Homeopaths	Other	

If "other", provide full details:

Name

Postal address

Postal code

Date

D D M M Y Y Y Y

Name

Postal address

Postal code

Date

D D M M Y Y Y Y

18. What is the general condition of your health, especially regarding your neck and back ailment/condition?

## 2: General questions (continued)

19. Have you in the past received any compensation (for your neck and back injury or symptoms) or do you expect to receive compensation in the near future (e.g. Road Accident Fund, Workmen's Compensation Commissioner, insurance or civil claims, etc.)?

Yes

No

If "yes", provide full details:

## 3: Declaration by insured life

I declare that all the statements that I have made and details that I have supplied in this form (whether in my own handwriting or not), are complete and true. I also understand and agree that the information that I have supplied, together with the application for life insurance and any other relevant documents, will form the basis of any insurance contract that may come into existence as a result of such application.

Signed at

Signature of insured life

Date

No payment for the completion of this form.