

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