

INSURANCE QUESTIONNAIRE

NAME : _____ AGE : _____ SEX : _____

ADDRESS : _____

DATE OF ACCIDENT : _____

TYPE OF ACCIDENT: () AUTOMOBILE () INDUSTRIAL () FALL () OTHER

WHERE AND WHEN DID THE ACCIDENT TAKE PLACE? _____

AREA OF BODY INJURED? () NECK () UPPER BACK () MID-BACK () LOW BACK

HAVE YOU EVER INJURED THIS AREA BEFORE? () YES () NO

STATE IN YOUR OWN WORDS HOW ACCIDENT HAPPENED AND DESCRIBE INJURIES RECEIVED:

OCCUPATION: _____

EMPLOYED BY: _____

DID YOU NOTIFY YOUR EMPLOYER: _____

DOES YOUR PRESENT JOB AGGRAVATE YOUR CONDITION? () YES () NO

HAVE YOU MISSED WORK SINCE THE ACCIDENT? _____ DAYS _____ WEEKS _____ MONTHS

DATES OF TOTAL DISABILITY FROM _____ TO _____

DATES OF PARTIAL DISABILITY FROM _____ TO _____

HAVE YOU BEEN SEEN BY ANY OTHER DOCTOR FOR THIS INJURY? () YES () NO

NAME OF DOCTOR: _____

WHAT WAS HIS DIAGNOSIS? _____

WERE YOU HOSPITALIZED? () YES () NO

IF SO, NAME HOSPITAL _____ DATE OF : _____

SINCE THE ACCIDENT HAS YOUR CONDITION: () IMPROVED () STAYED SAME () WORSENERD

DATE _____ SIGNATURE _____

Name _____ Date _____

CURRENT MEDICAL COMPLAINTS

NECK PAIN

My pain began: () gradually () suddenly

I have pain: () sometimes () all of the time

My pain goes into my: () right arm () left arm () both () none

I have tingling and/
Or numbness in my; () right arm () left arm () both () none

My pain is worse when I:

cough or sneeze	() yes	() no
bend forward	() yes	() no
lift	() yes	() no
push	() yes	() no
pull	() yes	() no
turn my head	() yes	() no

My pain wakes me up in the middle of the night: () yes () no

Changes in the weather affect my pain: () yes () no

The pain is: () sharp pain () stinging/burning () throbbing
 () stiffness () aching () catching

I have headaches: () yes () no

If I do get headaches, they occur: () sometime () all of the time

UPPER BACK PAIN

My pain began: () gradually () suddenly

The pain is: () sharp () dull () stinging/burning () throbbing

I have pain: () sometimes () all of the time

The pain goes into my: () ribs () shoulders () chest

The pain is aggravated
by movement: () yes () no

Does rest lessen pain: () yes () no

UPPER BACK PAIN cont.

My pain is worse when I:

- | | | |
|-----------------|------------------------------|-----------------------------|
| cough or sneeze | <input type="checkbox"/> yes | <input type="checkbox"/> NO |
| sit | <input type="checkbox"/> yes | <input type="checkbox"/> NO |
| bend | <input type="checkbox"/> yes | <input type="checkbox"/> NO |
| walk | <input type="checkbox"/> yes | <input type="checkbox"/> NO |
| lift | <input type="checkbox"/> yes | <input type="checkbox"/> NO |
| push | <input type="checkbox"/> yes | <input type="checkbox"/> NO |
| pull | <input type="checkbox"/> yes | <input type="checkbox"/> NO |

The pain wakes me up in the middle of the night: yes no
Changes in the weather affect my pain: yes no

LOW BACK PAIN

My pain began: gradually suddenly

The pain is: sharp dull stinging/burning throbbing

I have pain: sometimes all of the time

Does the pain go into
your legs: right leg left leg both none

I have tingling and/
or numbness in my: right leg left leg both none

Is the pain aggravated
by movement: yes no

Does rest lessen pain: yes no

My pain is worse when I:

- | | | |
|-----------------|------------------------------|-----------------------------|
| cough or sneeze | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| sit | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| bend | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| walk | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| lift | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| push | <input type="checkbox"/> yes | <input type="checkbox"/> no |
| pull | <input type="checkbox"/> yes | <input type="checkbox"/> no |

The pain wakes me up in the middle of the night: yes no

Changes in the weather affect my pain: yes no

Signature _____