



BACK PAIN QUESTIONNAIRE

NAME _____ FILE _____

1. Have you ever had pain or discomfort in your back or neck? Yes No

How many times? _____

Date of first episode _____ Date of last episode _____

Longest duration of discomfort? _____

Type of treatment received & date of last treatment? _____

Do you require ongoing treatment? _____

2. In which area of your back have you experienced pain or discomfort?

Neck (cervical) Middle (thoracic) Low (lumbosacral)

3. Does pain travel to other areas of body? Yes No

If **Yes**, Where? _____

4. What was the cause? _____

Was it work related? Yes No

Provide details: _____

Treatment: _____

5. Have you:

Undergone any x-rays or other investigation for your back? Yes No

Ever had or been advised to have surgery to your back? Yes No

Ever been hospitalized for any back or neck complaints? Yes No

Ever been disabled or unable to work because of back discomfort? Yes No

6. If any of above questions are answered **Yes**, please provide details below:

Details of **Yes** answer: _____

Date(s): _____

Duration of time off: _____

Name of physician and/or _____

Chiropractor: _____

Address: _____

DECLARATION:

I declare that the answers and statements to the above questions are complete and true to the best of my knowledge and belief. I understand they will form part of my application for insurance on my life.

I understand that if I do not fully, completely and truthfully answer the above questions (if I misrepresent my answers or statements) the Company may void this policy.

Date _____ Signature of Proposed Insured _____

PLEASE RETURN FORM TO:
 The Wawanesa Life Insurance Company, 400-200 Main Street, Winnipeg, MB R3C 1A8
 TOLL FREE: 1-888-997-9965 FAX: 1-888-985-3872 WEBSITE: wawanesalife.com