

Back / Spine Questionnaire

Claims Administrator:
Consociate • Dansig
Attn: Underwriting
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9088

Group name: _____

Employee name: _____

Dependent name (if condition is for dependent) _____

Age: _____ Height: _____ Weight: _____

1. Condition diagnosed: Muscle sprain/spasm Disc/vertebra disorder sciatica
Scoliosis of the spine Other: _____

2. When were you first diagnosed with back problem? _____

3. What area of the back/spine is affected? _____

Circle all that apply: Neck Upper back Lower back

If scoliosis of spine, what degree? _____

4. Symptoms experienced? _____

5. Cause of condition (i.e. injury due to accident, work related, or acute onset):

6. Any physical therapy or chiropractic manipulation required? Yes or No

Duration of therapy: _____

7. Any surgical intervention or hospitalization required? Yes or No

Date release form MD: _____

Date	Procedure performed	Results
_____	_____	_____
_____	_____	_____
_____	_____	_____

Any further surgery or treatment required or recommended in the future? Yes or No

If so, when and what reason? _____

8. Current medications Dosage Frequency

_____	_____	_____
_____	_____	_____
_____	_____	_____

9. Any complications? Residuals? Limitations? Loss of mobility? _____

Please be advised that you may be required to submit medical records.

Employee signature: _____ Date: _____

