

Knee Disorders 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. Type of injury (i.e. torn ACL, dislocated knee cap, other) _____

2. Treatment received? _____

3. Any physical therapy? When? How frequent? When released? _____

4. Any restrictions of movement? _____

5. Any surgery? Type? When? _____

6. Any pins or rods? _____

7. Have they removed the pins or rods? _____

If not, when is the proposed date? _____

8. Are you currently taking any medications? _____

Medication name	Dosage	Frequency
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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

Employee signature: _____ Date: _____

