

Musculoskeletal Disorder 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. Name of condition diagnosed _____ Date of onset _____

2. What were the symptoms experienced? _____

3. Location? _____

4. Any physical therapy required? If so, when? How long was/is therapy required?

5. Any surgery performed? Yes or No If so, what type? When? _____

6. Any restrictions of movement? _____

7. Any permanent disability? _____

8. List all medications taken

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

9. Are you being treated for any other medical condition(s)? _____

If so, please list them: _____

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

Employee signature: _____ Date: _____

