

BACK DISORDER QUESTIONNAIRE

Rohrer & Associates

Insured's Name: _____ DOB: _____ State: _____ Sex: M / F
Height: _____ Ft. _____ In. _____ Weight: _____ Face Amount: _____
Tobacco use in the past 5 years: No Yes Details: _____
Producer: _____ State: _____ Phone: _____ E-mail: _____

Proposed Insured please answer the following:

1. When did you first notice back discomfort?
2. How often does the pain occur?
3. Where is the pain located?
4. Where does the pain extend to?
5. How long does the pain last?
6. What causes the pain?
7. Are you limited in any way due to your pain? Yes No
Details: _____
8. Have you ever missed work due to the back pain? Yes No
Details: _____
9. What is the actual diagnosis?
10. Are you on any medication(s)? Yes No
Name(s) and dosage(s): _____
11. Have you seen a chiropractor along with your regular physician? Yes No
Name(s) & address(es): _____
12. Name, address & phone number of your physician(s) and the date last consulted:

Additional Information (please use reverse side for additional space):

Date: _____ Insured's Signature: _____