NAME	
FIRST NAME	
DATE OF BIRTH (D / M / Y)	APPLICATION OR POLICY NUMBER

BACK PAIN QUESTIONNAIRE

1. **Date of first back pain episode:** _____
2. **Have you had more than one episode:** Yes ☐ No ☐
   If yes, provide complete details: _____
3. **Which activities tend to induce pain?** _____
4. **How frequently do symptoms occur?** _____
5. **Name of the doctor(s) consulted and date(s):** _____
6. **Diagnosis:** _____
7. **Have you undergone any investigations on your back?** Yes ☐ No ☐
   If yes, provide full details and final results: _____
8. **Have you had medications prescribed:** ☐ Yes ☐ No
   If yes, please complete the following table:

Name of medication	Dosage	Frequency	Date of last used

9. **Have you ever had any chiropractic treatments, physiotherapy, osteopathy, etc.?** Yes ☐ No ☐
   If yes, please complete the following table:

Type of treatment	Name of practitioner or clinic	Address	Frequency	Date of last consultation

10. **Have you or ever had any restriction of your activities because of the discomfort?** Yes ☐ No ☐
    If yes, provide complete details: _____
    _____
11. **Have you ever been disabled or unable to work because of back discomfort?** Yes ☐ No ☐
    Date: From____/_____/_____ To_____/_____/____ **More than once Date:** From____/____/____ To____/_____/____
12. **Are you completely free of back symptoms?** Yes ☐ No ☐
    If no, provide complete details: _____
13. **Have you had any recurrence of symptoms?** Yes ☐ No ☐
    If yes please provide details: _____
14. **Do you have any sequel or side effects?** _____

I declare that all statements and answers provided above are complete and true and that the information shall form part of my insurance application with **UL Mutual**.

X_____ X_____
SIGNATURE OF THE PROPOSED INSURED **SIGNATURE OF THE POLICY OWNER**

X_____ _____
WITNESS **DATE**