



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

MUSCULOSKELETAL DISORDER QUESTIONNAIRE

1. Date the injury occurred: _____ / _____ / _____
D M Y

2. Please provide the precise location of the pain or injury: _____

3. How did the injury occur? _____

4. How frequently do symptoms occur? _____

5. Diagnosis: _____

6. Have you had medications prescribed: Yes No If yes, please complete the following table:

Name of medication	Dosage	Frequency	Date of last used

7. 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

8. Did the injury require the necessity to use any orthopedic equipment? Yes No
 If yes, provide complete details: _____

9. Have you had any surgery (ies)? Yes No If yes, provide complete details: _____
 Date: _____ / _____ / _____ D M Y Name and address of the hospital: _____

10. Time off work: From _____ / _____ / _____ To _____ / _____ / _____
D M Y D M Y
 If more than once: From _____ / _____ / _____ To _____ / _____ / _____
D M Y D M Y

11. Have you fully recovered? Yes No If yes, since when: _____ / _____ / _____
D M Y
 If no, provide complete details: _____

12. Do you have any permanent physical damage: _____

13. Name(s) and address(es) of the doctor(s) consulted: _____

14. Is there any other medical consultations or treatments foreseen in the future: _____

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 _____ SIGNATURE OF THE PROPOSED INSURED	X _____ SIGNATURE OF THE POLICY OWNER
X _____ WITNESS	_____ DATE