



**BACK PAIN or SPINE IMPAIRMENT QUESTIONNAIRE**

NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

POLICY NO.: \_\_\_\_\_ GASC NO.: \_\_\_\_\_

1. Exact Diagnosis: \_\_\_\_\_

2. Exact area involved (upper, middle, or lower): \_\_\_\_\_

Radiating to: \_\_\_\_\_

3. Date of first attack: \_\_\_\_\_

4. Date of last attack: \_\_\_\_\_

5. Duration and severity of attacks (dates): \_\_\_\_\_

\_\_\_\_\_

6. Duration and dates of disability (loss of work time): \_\_\_\_\_

\_\_\_\_\_

7. Are you limited in any way (i.e. pain, residual disabilities) Yes \_\_\_\_\_ No \_\_\_\_\_

If yes, please provide details \_\_\_\_\_

\_\_\_\_\_

8. Description of treatment (medication, manipulation, heat treatment, exercise, etc.) \_\_\_\_\_

\_\_\_\_\_

9. Frequency of treatment: \_\_\_\_\_

10. Monthly cost of medication and/or treatment: \_\_\_\_\_

11 Please give names and addresses of all doctors consulted (include dates of consultations)

\_\_\_\_\_

\_\_\_\_\_

12. Have you completely recovered from your condition:

If yes, please provide date of full recovery: \_\_\_\_\_

If no, please provide details: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

DATE

\_\_\_\_\_

SIGNATURE