



Back Disorder Questionnaire

Name: _____

Date of Birth: _____

Height: _____ Weight: _____

Sex: M/F

Tobacco Usage: _____

Face Amount: _____

___Term 10 15 20 30

___UL

1. Has there been a diagnosis of the back disorder? ___Yes ___No

(If yes, please give details): _____

2. Does the proposed insured require assistance on a regular basis as a result of back disorder?

___Yes ___No (If yes, please provide details): _____

3. Is, the proposed insured, receiving disability benefits as a result of back disorder?

___Yes ___No (If yes please provide details): _____

4. Does the proposed insured regularly receive physical therapy or treatment from a chiropractor?

___Yes ___No (if yes, please provide details): _____

5. Does the proposed insured have any other major health problems? ___Yes ___No

(If yes, please provide details): _____

6. Is the proposed insured taking medication for this condition or any other? ___Yes ___No

If yes, please provide name, dosage, and frequency): _____
