Return to - jim@uswolfe.com or Fax to 815-377-3556

BACK DISORDER QUESTIONNAIRE

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: _____