

Spinal Questionnaire

Addendum to Application for Health Insurance

(Complete all questions. Please contact your physician for assistance if necessary.)

Name of primary applicant: _____ ID/SSN: _____

Form No. _____

Name of person treated: _____ Relationship to applicant: _____

1. Have you ever suffered pain in any of the following areas? Please check all that apply.

- Neck (cervical) Middle back (thoracic) Lower back (lumbosacral)

If yes, please describe how often you had pain and the severity: _____

Does the pain radiate to legs/feet or shoulders/arms/hands? Yes No If yes, please describe: _____

Do you have numbness or tingling sensations in your arms or legs? Yes No If yes, please describe: _____

2. Please give diagnosis if known: _____

3. Have you ever been diagnosed with any of the following disc disorders? Check all that apply.

- DJD (degenerative joint disease)/Arthritis Herniation Rupture Protrusion (bulging)

4. Was this a result of an injury/accident? Yes No If yes, please describe: _____

5. Have you ever been diagnosed with Scoliosis? Yes No If yes, please state degree of curvature if known: _____

6. Have you ever taken prescription medication for pain or muscle spasms in your back or neck? Yes No If yes, please list:

Name of medication Amount taken per day How often per day

7. Have you ever had or been advised to have surgery or spinal fusion? Yes No If yes, provide details: _____

8. Have you ever had or currently use chiropractic treatment for your back or neck condition? Yes No If yes, how often per month? _____ Date last seen: _____

9. Have you ever had or currently use physical therapy treatment for your pain? Yes No If yes, please describe length and type of treatment: _____

10. Have you ever had any of the following testing on your back/neck?

- CT scan Myelogram X-ray MRI

If yes, please give dates of testing and results: _____

11. Have you ever lost time at work or had restrictive activities due to your condition? Yes No If yes, please describe:

12. Are you experiencing pain in your neck or back now? Yes No Are you being treated for pain now? Yes No
If yes, please describe treatment: _____

13. Name and address of treating physician: _____

14. Please list your current height: _____ weight: _____

All of the above statements are true, complete and correctly recorded to the best of my knowledge. I understand American Community will rely on these statements when determining eligibility.

Signature of person treated (or parent/guardian if under 18)

Date