beneva

Questionnaire
Back and neck disorders

First and last names of insured _____

Y Y Y Y M M D D
Date of birth

Policy / application number

1. a) What is the nature of back or neck disorders?

- ☐ Osteoporosis
- ☐ Arthrosis / Osteoarthritis
- ☐ Scoliosis / Lordosis
- ☐ Disc degeneration
- ☐ Sprain
- ☐ Sciatic nerve problem
- ☐ Lumbago (acute lower back pain)
- ☐ Herniated disc
- ☐ Torticollis (wryneck)
- ☐ Arnorld's neuralgia
- ☐ Fracture
- ☐ Ankylosing spondylitis
- ☐ Other (specify): _____

b) What is the affected part (neck, upper back, middle back, lower back, coccyx)?

Condition	Localisation	Date of first symptoms
		Y Y Y Y M M
		Y Y Y Y M M
		Y Y Y Y M M

2. Is there a known cause? ☐ Yes ☐ No

If yes, specify:

Condition	Cause
	☐ Accident ☐ Sports practice ☐ Repetitive movement ☐ Other (specify):
	☐ Accident ☐ Sports practice ☐ Repetitive movement ☐ Other (specify):
	☐ Accident ☐ Sports practice ☐ Repetitive movement ☐ Other (specify):

3. Have you consulted or will you consult doctors or therapists for any of the conditions mentioned above?
☐ Yes ☐ No

if yes, complete the information below:

Condition: _____

Name and specialty: _____

Address: _____

Date of first consultation: Y Y Y Y M M _____

Date of last consultation: Y Y Y Y M M Results: _____

Frequency of the consultations: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 by ☐ Week ☐ Month ☐ Year

Date of next consultation: Y Y Y Y M M ☐ No more consultation to come

3. Have you consulted or will you consult doctors or therapists for any of the conditions mentioned above? (continued)

Condition: _____

Name and specialty: _____

Address: _____

Date of first consultation: Y Y Y Y M M _____

Date of last consultation: Y Y Y Y M M Results: _____

Frequency of the consultations: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 by ☐ Week ☐ Month ☐ Year

Date of next consultation: Y Y Y Y M M ☐ No more consultation to come

Condition: _____

Name and specialty: _____

Address: _____

Date of first consultation: Y Y Y Y M M _____

Date of last consultation: Y Y Y Y M M Results: _____

Frequency of the consultations: ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 by ☐ Week ☐ Month ☐ Year

Date of next consultation: Y Y Y Y M M ☐ No more consultation to come

4. Have any tests or examinations been done? ☐ Yes ☐ No

If yes, specify:

Test / examination	Condition	Results	Date
☐ MRI			Y Y Y Y M M
☐ X-Ray			Y Y Y Y M M
☐ Scan			Y Y Y Y M M
☐ Blood test			Y Y Y Y M M
☐ Other: _____			Y Y Y Y M M

5. Have any tests, examinations or treatments been recommended that have not yet taken place? ☐ Yes ☐ No

If yes, specify the condition, type of test, examination or treatment and anticipated date.

_____ Date: Y Y Y Y M M

_____ Date: Y Y Y Y M M

6. Are you taking or have you taken medication(s) for any of the conditions mentioned above? ☐ Yes ☐ No

If yes, specify:

Condition: _____

Medication: _____ Dosage: _____

Start date: Y Y Y Y M M End date: Y Y Y Y M M or ☐ Still using

Condition: _____

Medication: _____ Dosage: _____

Start date: Y Y Y Y M M End date: Y Y Y Y M M or ☐ Still using

Condition: _____

Medication: _____ Dosage: _____

Start date: Y Y Y Y M M End date: Y Y Y Y M M or ☐ Still using

7. Have you undergone or have you been advised to undergo surgery for any of the conditions mentioned above? ☐ **Yes** ☐ **No**

If yes, specify:

Type of surgery	Condition	Date
		Y Y Y Y M M
		Y Y Y Y M M
		Y Y Y Y M M

8. Do you have limitations in your activities of daily living, in your work schedule or in your leisure time because of any of the conditions mentioned above? ☐ **Yes** ☐ **No**

If yes, specify the condition and limitations: _____

9. Have you had to take time off work / school because of any of the conditions mentioned above? ☐ **Yes** ☐ **No**

If yes, specify:

Condition	Start date	Duration (in weeks)
	Y Y Y Y M M	
	Y Y Y Y M M	
	Y Y Y Y M M	

10. What is your current state?

Specify:

Condition	Current state
	☐ Completely recovered: date of last symptoms Y Y Y Y M M ☐ Sequelae, specify:
	☐ Completely recovered: date of last symptoms Y Y Y Y M M ☐ Sequelae, specify:
	☐ Completely recovered: date of last symptoms Y Y Y Y M M ☐ Sequelae, specify:
	☐ Completely recovered: date of last symptoms Y Y Y Y M M ☐ Sequelae, specify:

11. Additional information

12. Declaration

I acknowledge having fully understood all of the questions above and that the answers given are true and complete. In addition, I consent to having them as an integral part of the requested insurance policy.

X _____ Y Y Y Y M M D D

Signature of insured (signature of the father, mother or legal guardian if the insured is a minor) Date of signature