Questionnaire

Musculo-Skeletal

Mr. ❑ **Mrs.** ❑ **Miss** ❑ **Ms.** ❑ **Other** ❑

SURNAME: .... **FIRST NAME(S)**: ....
Address : ....
Date and Place of birth : …………………………………………. Profession : ....

		YES	NO	**Please specify :**
1	**Disorder/Disease**			
	Please state the precise diagnosis, if known	☐	☐	………………………………………………….………..
	Please indicate areas/joints affected (e.g. back, neck etc)	☐	☐	…………………………………………………………..
	When was this condition first diagnosed?	☐	☐	Date: ……./…………./………… Result
	Have you had any x-rays?	☐	☐	Date: ……./…………./………… Result
	Or other medical investigations?	☐	☐	If yes, please specify Date: ……./…………./…………
	Have you had an operation or is an operation being considered?	☐	☐	Full details
2	**Treatment**			
	Please provide details of your treatment?			Please specify names of medication, dosage and how often taken
	Currently	☐	☐	
	In the past	☐	☐	
	Please provide details of any physiotherapy, chiropractor, osteopath or alternative treatment?			Please specify date(s) and duration of treatment
	Currently	☐	☐	
	In the Past	☐	☐	
	How often do you attend for follow-up?	☐	☐	………………………………………………………..
	When was your last consultation?	☐	☐	………………………………………………………..

3	**Symptoms**	YES	NO	
	Please describe your symptoms			
	Can you indicate frequency of symptoms/attacks?	☐	☐	Per month
		☐	☐	Per year
	When was the last occurrence of symptoms/attack?			Date: ……./…………./…………
	Are your activities restricted in any way?	☐	☐	
	Have you been off work with this condition?	☐	☐	If yes, please specify date(s) and duration
	Have you any limitations of physical activity	☐	☐	
	Have there been any episodes of associated anxiety or depression?	☐	☐	If yes, please specify date(s) and duration

It is imperative that this questionnaire be completed by the insurance applicant; all the questions must be completed. Applicants should be advised to consult their doctor or any other medical practitioner if they are not confident they will remember to disclose all health details that may be relevant.

I authorise your company to forward this information to its Reinsurers and approved professional organisations. I agree this form will constitute part of my application for Income Protection and that failure to disclose any material fact known to me may invalidate the contract.

I declare that to the best of my knowledge the answers I have given (whether in my handwriting or not) are true and complete. I confirm I have read and understand the disclosure notes in this form.

Name .... Date................................. 20……..
Signature of the insurance applicant

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