Musculoskeletal Questionnaire

Last Name: _____ First Name: _____
Please Print

Date of Birth: _____ Policy/Application Number: _____

1. Please advise which joint/s or areas of the body are/were affected.

2. What was the underlying cause (e.g. accident, degeneration, recreational or sporting injury etc.)?

3. When did you first experience symptoms? / /

4. a) Are your symptoms ongoing? ☐ Yes ☐ No
   b) If yes, are your symptoms: ☐ improving ☐ getting worse ☐ unchanged
   c) If you are no-longer experiencing symptoms, when did they last occur? / /

   Please also advise how often or how many times you have ever experienced symptoms and how long the symptoms have lasted on these occasions?

5. Please provide details of any medication taken for this condition:

Name of medication	Dose	Frequency	Date last taken

6. Please provide details of any other treatment that you have had for this condition e.g. arthroscopy, other surgery, treatment by a physiotherapist, massage therapist, acupuncturist, naturopath etc.

Type of treatment	Name of practitioner or clinic	Address	Date of last consult

7. Have you ever had any tests or investigations carried out in connection to this condition e.g. x-ray, MRI, CT scan etc.? ☐ Yes ☐ No
   If yes, please provide details:

Name of test or investigation	Location	Date	Result

8. Have you ever been admitted to hospital or had out-patient follow-up for this condition? ☐ Yes ☐ No
   If yes, please provide details including dates, procedures, locations and results:

9. Has any further treatment or investigation been discussed or contemplated? ☐ Yes ☐ No
If yes, please provide details:

10. Please provide details regarding the doctors and/or specialists you see in relation to this condition:

Name of doctor, hospital or clinic	Address	Dates

11. Have you ever taken time off work with this condition? ☐ Yes ☐ No
If yes, please provide details including dates and durations:

12. Have your working duties ever been affected or restricted in any way? ☐ Yes ☐ No
If yes, please provide details including dates and durations:

13. Please provide any additional information that you feel is important:

Declaration

I confirm that the answers I have given are, to the best of my knowledge, true, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance(s) and that failure to disclose any material fact known to me may invalidate my insurance(s).

	x	/ /
Name	Signature	Date