

BACK DISORDERS

Please fax back to IPA at 781 643-2775

Name: _____ DOB: _____

1. When did the proposed insured first notice back discomfort? _____

2. How often does the pain occur? _____

3. What is the location of the pain? _____

4. Where does the pain radiate to? _____

5. How long does the pain last? _____

6. What causes the pain? _____

7. What was the actual diagnosis? _____

8. Are you on any medication, if so, please indicate? _____

9. Are you limited in anyway due to your pain? _____
10. Have you ever missed work due to the back pain, if so, please give details? _____

11. What is the name of the proposed insured's physician? _____

12. Have you seen a chiropractor along with your regular physician, if so, please indicate name and address? _____

Agent Name: _____

Phone Number: _____ Fax No: _____

Date: _____ E-mail Address: _____

Please circle the associate you work with. Russ, Rhonda, Leo