La Capitale

MUSCULOSKELETAL DISORDERS QUESTIONNAIRE

Last name: ____________________ First name: ____________________

Date of birth: ____ Year ____ Month ____ Day

Application or Contract No.: ____________________

1 a) What is the nature of your musculoskeletal disorder?

☐ Arthritis ☐ Fracture ☐ Muscle strain ☐ Sprain
☐ Bursitis ☐ Ligament tear ☐ Osteoarthritis ☐ Tendinitis
☐ Epicondylitis ☐ Meniscus tear ☐ Plantar fascitis ☐ Other: ____________________

b) Which part of the body is affected?

☐ Right ankle ☐ Left ankle ☐ Both ankles
☐ Right elbow ☐ Left elbow ☐ Both elbows
☐ Right shoulder ☐ Left shoulder ☐ Both shoulders
☐ Right knee ☐ Left knee ☐ Both knees
☐ Right hip ☐ Left hip ☐ Both hips
☐ Right wrist ☐ Left wrist ☐ Both wrists

☐ Other (specify affected side): ____________________

2 Onset of symptoms: ____ Year ____ Month

3 Is the cause known? ☐ Yes ☐ No

If so, specify whether it is due to ☐ Illness ☐ Accident ☐ Participation in sports ☐ Workplace repetitive motion

If so, specify. ____________________

4 Are the symptoms still present? ☐ Yes ☐ No

If so, specify whether they are ☐ Continual ☐ Occasional **If occasional,** specify the frequency. ____________________

If no longer present, specify the date and the length of the last episode. ____ Year ____ Month ____ Length

5 Name and mailing address of all physicians or other healthcare professionals consulted for this condition.

Name	Address	Date of consultation
		Year Month
		Year Month
		Year Month

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, Quebec QC G1R 2G5

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6 Have you been advised to consult a specialist? ☐ Yes ☐ No

If so, specify the dates of upcoming consultations and the specialist's name and mailing address.

Name	Address	Date of consultation (Year / Month)

7 Are you taking any medication for this condition? ☐ Yes ☐ No

If so, specify. ______________________________

If not, have you ever done so? ☐ Yes ☐ No

If so, specify the medications, the reason and the cessation date. ______________________________

____

____

8 Were any tests or examinations performed? ☐ Yes ☐ No **If so**, specify.

Test/examination	Result	Date
☐ MRI		Year / Month
☐ X-ray		Year / Month
☐ Scan		Year / Month
☐ Other: ______		Year / Month

9 a) Are you receiving or have you received treatment? ☐ Yes ☐ No **If so**, specify the type and frequency.

Type of treatment	Frequency	From	To
☐ Acupuncture		Year	Year
☐ Kinesitherapy		Year	Year
☐ Massage therapy		Year	Year
☐ Naturopathy		Year	Year
☐ Occupational therapy		Year	Year
☐ Osteopathy		Year	Year
☐ Physiotherapy		Year	Year
☐ Other: ______		Year	Year

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b) Have you been advised to undergo tests or examinations or to receive treatments that have not yet taken place? ☐ Yes ☐ No

If so, specify the type of test, examination or treatment and the date scheduled.

	Date
	Year Month
	Year Month

c) Have you been advised to undergo treatments that you have decided not to receive? ☐ Yes ☐ No

If so, specify the type of treatment and the reason for your decision.

10 Have you had or will you have to have surgery? ☐ Yes ☐ No **If so**, specify.

Surgical procedure	Name of hospital	Date
		Year Month
		Year Month

11 Does this condition limit you in your activities of daily living, in your work or in your leisure activities? ☐ Yes ☐ No

If so, specify.

12 Have you ever had to go on disability leave because of this condition? ☐ Yes ☐ No

If so, specify the start date and length of each disability period.

Start date	Length (number of weeks)
Year Month	
Year Month	

13 Did you make a full recovery? ☐ Yes ☐ No **If so**, specify the date of the last symptoms. Year Month

I hereby acknowledge and agree that the answers to the questions in this questionnaire are true and complete.

Signed at ______ on this ______ day of ______ 20 ______ .

X

Signature of proposed insured or of legal guardian, if the proposed insured is under age 18 in Quebec or under 16 in other provinces.

X

Signature of witness

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