La Capitale

BACK OR NECK DISORDERS QUESTIONNAIRE

Last name

First name

Date of birth: Year Month Day

Application or Contract No.

1 a) What is the nature of your back or neck disorder?

- ☐ Back fatigue
- ☐ Herniated disc
- ☐ Low back strain
- ☐ Lumbago
- ☐ Neck/nape fatigue
- ☐ Occipital neuralgia
- ☐ Osteoarthritis
- ☐ Pinched sciatic nerve (sciatica)
- ☐ Scoliosis, lordosis
- ☐ Spondylosis
- ☐ Sprain
- ☐ Whiplash injury

b) Area affected ☐ Neck ☐ Middle back ☐ Lower back

If more than one area is affected, information for each of them must be indicated.

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 ☐ Congenital deformity

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

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

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

La Capitale Financial Security Insurance Company
7150 Derrycrest Drive, Mississauga ON L5W 0E5

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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
☐ Scan		Year Month
☐ X-ray		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
☐ Epidural		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

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

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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 _____ 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.

Signature of witness

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