

The Brokerage Resource, Inc.
BACK DISORDER QUESTIONNAIRE

Proposed Insured's Name: _____ DOB: _____ Sex: M F
Tobacco Use: Yes No Amount: _____ Height: _____ Ft. In. Weight: _____
Broker's Name: _____ Face Amount: _____
Address: _____ Phone: _____ Fax: _____

Proposed Insured please answer the following:

1. When did you first notice back discomfort?
2. How often does the pain occur?
3. Where is the pain located?
4. Where does the pain extend to?
5. How long does the pain last?
6. What causes the pain?
7. Are you limited in any way due to your pain? No Yes, Details:
8. Have you ever missed work due to the back pain? No Yes, Details:
9. What was the actual diagnosis?
10. Are you on any medication(s)? No Yes, Name(s) and dosage(s):
11. Date you last consulted your physician: _____
12. Have you seen a chiropractor along with your regular physician? No Yes
Name(s) and Address(es): _____
13. Name and address of your physician(s): _____

This information is confidential return to NBA member only.

Date: _____ Proposed Insured's Signature: _____