AXA AFFIN

redefining / standards

BACK & NECK QUESTIONNAIRE

Name: ______________________________

Policy/Application Number: ______________________

1. Please state the precise diagnosis, or nature of the disorder e.g. simple back strain, degenerative disk disease, herniated disk, lumbago, sciatica, spondylosis, spondyloarthropathy, whiplash, etc.:

2. When was the condition diagnosed or when did you first experience symptoms? / /

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

4. Please advise which part of your back is or was affected, e.g. cervical spine (neck), thoracic spine (upper middle) or lumbar spine (lower) and describe your symptoms including details of any radiation down either the arms or legs:

5. a) Are symptoms ongoing? ☐ Yes ☐ No
   If yes, are the symptoms decreasing, remaining stable or worsening in severity?

   b) When did you last experience symptoms? / /

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

6. Have your daily activities ever been affected or restricted in any way? ☐ Yes ☐ No
   If yes, please provide details:

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

Name of medication	Dose	Frequency	Date last taken

8. Please provide details of any other treatment that you have had for this condition, e.g. surgery, treatment by a physiotherapist, chiropractor, osteopath, massage therapist, acupuncturist etc.:

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

AXA AFFIN Life Insurance Berhad (723739W)
8th Floor, Chulan Tower, No.3 Jalan Conlay, 50450 Kuala Lumpur Telephone: 03-2117 6688 Fax: 03-2117 3698
1 300 88 1616 www.axa.com.my

9. Have you ever had any tests or investigations carried out in connection with this condition, e.g. x-ray, MRI, CT scan or nerve conduction studies? ☐ Yes ☐ No
If yes, please provide details including dates, procedures, locations and results:

Name of test or investigation	Location	Date	Results

10. Have you ever been admitted to hospital for this condition? ☐ Yes ☐ No
If yes, please provide details including dates, procedures, locations and results:

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

12. Please provide the name and address of the doctors and/or specialists you see in relation to this condition:

Name of doctor, hospital or clinic	Address	Dates

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

14. Have your working duties ever been affected or restricted in any way, e.g. restricted ability to drive, lift, carry objects, bend, walk, run or sit for prolonged periods? ☐ Yes ☐ No
If yes, please provide details including dates and durations

15. Have you experienced any associated anxiety or depression? ☐ Yes ☐ No
If yes, please provide details including dates and durations:

16. 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).

Name	Signature x	Date / /

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