

Self-declaration – Back and Spine

It is mandatory for all applicants to complete this form

Name: _____ **DOB:** ____ / ____ / ____

Have you ever suffered from back pain in the past? **Yes No**

If Yes,

A. When? Year/ Year/ Year/ Year/ Year/ (If more than once, list all times)

B. What symptoms and signs did you have? a. Pain all over? b. Low or high back pain? c. Pain also when resting? d. Pain radiating to buttocks, legs or arms? e. Other

C. What kind of investigations did you go through:

* Examination by general practitioner or seaman’s doctor. **Yes (who? Name, Address and Date of exam) No**

* Examination by specialist? **Yes (what type of specialist? Name, Address and Date of exam) No**

* Examination by other health professionals (chiropractor, physiotherapist, masseur, other? **Yes No**

* X-rays of back/spine **Yes (Name, Address and Date of exam) No**

* Ultra sound/sonogram, Bone Scan, MRI or CT **Yes (Type of exam? Name, Address and Date of exam) No**

D. What was the diagnosis (= what were you told was wrong with your back?)

E. What do you think was the cause: a. Overwork / Over-exertion? Yes No b. Acute injury? Yes No c. Infection? Yes No d. Other Yes. What? **No**

F. Did you receive any kind of treatment? **Yes No**

If Yes, what kind of treatment:

Medicine	Yes What type? <input type="text"/>	How long? <input type="text"/>	No
Massage	Yes		No
Physiotherapy	Yes What type? <input type="text"/>	How long? <input type="text"/>	No
Manipulation by Chiropractor	Yes What type? <input type="text"/>	How long? <input type="text"/>	No
Surgery	Yes What type? <input type="text"/>	How long? <input type="text"/>	No

G. Who treated you? (Profession, Name, and Address of all health professionals involved)

H. Did your back pain lead to:

Sick leave from work	Yes How long? <input type="text"/>	No
Medical Sign-Off	Yes When & where? <input type="text"/>	No
Disability pay	Yes How long and by whom? <input type="text"/>	No

I. How are you now?

Fully recovered	Yes	No
Recovered, but must be careful with certain types of action	Yes Which types? <input type="text"/>	No
Still suffer from back pain	Yes Describe <input type="text"/>	No
Other	<input type="text"/>	

I acknowledge that the above statements are true and accurate and accept that if any of them are false in any way it will subject me to immediate termination of employment and may prejudice my benefits. I hereby authorize release of any and all medical records in relation to any injury/illness claims to my employer or their insurance providers.

Place **Date** **Signature**