Mailing Address:
175 Scott Swamp Road
PO Box 4058
Farmington, CT 06034-9863
Fax: (860) 674-2862

Supplement to SOLO® Application
BACK/NECK/SHOULDER PAIN QUESTIONNAIRE

Name of primary applicant: ___________________________. ID/SSN: ____________________________.

Name of person related to condition: ____.

1. Have you ever had pain, a strain/sprain in your back, neck or shoulder(s) or have ruptured or had a bulged, herniated or slipped disc? Yes or No: ________. If yes, complete the following:
   a. How many times: ___________.
   b. Date of first episode: ___________.
   c. Date of last episode: ___________.

2. What area(s) involved? (Check appropriate areas):
   __Neck (cervical) __Middle (thoracic) __Low (lumbosacral)

3. Does the pain radiate? Yes or No: ______. If yes, where? _________________________________.

4. What was the diagnosis? _________________________. Date of last symptom? ______________.

5. Was this the result of an injury? Yes or No: _______. If yes, please provide details:
   ____.

6. Do you currently take prescription medication? Yes or No: ____. If yes, provide the name, dosage and frequency with which you take it:
   ____.

7. Have you ever had or been advised to have surgery/or spinal fusion? Yes or No: ________.
   If yes, please explain when and give details:
   ____.

8. Have you ever had or now have chiropractic treatment or physical therapy? Yes or No: __________.
   If yes, how often do you go? ___________________________. Date last seen? ______________.

9. What is your current occupation? ____. Have you ever lost time from work? Yes or No: ________. If yes, how long were you off work? _____________.
   When did you return to work? ________________.

10. Has further treatment or surgery been advised? Yes or No: ________. If yes, please give details:
    ____.

11. Do you have any residuals or limitations? Yes or No: ___________. If yes, please explain:
    ____.

12. Please provide the name and address of the current treating physician:
    ____.

All of the above statements are true, complete and correct to the best of my knowledge. I understand and agree that this form is part of my application for coverage and that ConnectiCare will also rely on these statements when determining eligibility.

Signature of Applicant (or parent/guardian if under 18): ____.
Today's Date: __________________________.