

**Joint/Musculoskeletal Questionnaire**

Title  Surname

Given name(s)

Date of birth

1 Which joint(s) or area(s) of the body are affected? *(Advise if left or right joint, where applicable)*

2 What is/was the nature of the joint disorder, including symptoms?

3 What is the cause of the disorder?

4 When did the symptoms first occur?

5 When did you last experience symptoms?

6 Do you continue to experience symptoms?  
No  **Go to Question 9**  
Yes

7 What are your current symptoms?

8 How often do you experience symptoms?

9 What treatment have you had?

10 Are you still undergoing treatment?  
No  When did treatment cease?   
Yes

11 Have you had an x-ray or other test?  
No   
Yes  Please provide details, including dates and results

12 Please advise the names and addresses of any doctor, physiotherapist or chiropractor consulted.  
Name   
Address   
 State  Postcode

Name   
Address   
 State  Postcode

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13 Have you lost time from work due to this disorder?

(a) In the last 12 months?

No

Yes

From	To
/ /	/ /
/ /	/ /
/ /	/ /

(b) Prior to the last 12 months?

No

Yes

Please provide full details of all periods of time off work including dates


**DECLARATION**

The answers to the questions above are true and complete and this supplementary questionnaire forms part of my application for insurance.

**Signature**

X	Date / /
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Please return this completed form to:

**Smartsave**  
PO Box 1282  
Albury  
NSW 2640