

## Additional questionnaire

as a supplement to the application resp. demand for an offer from: \_\_\_\_\_

(does not replace answering the health questions in the application resp. demand for an offer)

## Spine diseases

**Incorrect or incomplete information may entitle us - depending on fault - to withdraw from the contract, to terminate it or to adjust it, which can lead to the insurer being released from performance - even for insured events that have already occurred. Please also note the "Information of the Consequences of the Violation of the Disclosure Obligation" in the application.**

**We ask you not to send us any results or data of genetic examinations or analysis!  
You only have to inform us of already existing complaints, pre-existing conditions, no matter by which examination methods you have acquired this information.**

What was the medical doctor's diagnosis for the disease?

- |   |  |
|---|--|
| <input type="checkbox"/> intervertebral disc prolapse                           | <input type="checkbox"/> Bechterew's disease   |
| <input type="checkbox"/> intervertebral disc protrusion                         | <input type="checkbox"/> Scheuermann's disease |
| <input type="checkbox"/> spinal column degeneration (e. g. arthrosis)           | <input type="checkbox"/> osteoporosis          |
| <input type="checkbox"/> spinal curvature (e.g. scoliosis)                      | <input type="checkbox"/> spine malposition     |
| <input type="checkbox"/> vertebral body slipping                                | <input type="checkbox"/> tensions, myalgia     |
| <input type="checkbox"/> sciatica   | <input type="checkbox"/> low back pain         |
| <input type="checkbox"/> spine syndrome   |  |
| <input type="checkbox"/> cervical spine <input type="checkbox"/> thoracic spine |  |
| <input type="checkbox"/> lumbar spine   |  |
| <input type="checkbox"/> others, which ones?                                    |  |
-

Is there an underlying disease or cause?  yes  no

If "yes", which ones?

---

Is it a rheumatic disease?  yes  no

If "yes", which ones?

---

What symptoms/complaints do you have?  
(e.g. movement disorders, joint pain, joint swelling, nerve pain/neuralgia, inflammations)

---

When did the complaints first occur?

---

When did the complaints last occur?

---

How often did the complaints occur  
and for how long?

---

Is there a shortening of the leg?  yes  no

If "yes", by how many cm?

---

How is this compensated (e.g. insoles, heel increase, orthopedic shoes)?

---

What examinations have been performed so far or are recommended?

<input type="checkbox"/> ultrasonic examination (sonography)	when? _____	how often? _____
<input type="checkbox"/> X-ray examination	when? _____	how often? _____
<input type="checkbox"/> computer tomography (CT scan), magnetic resonance tomography	when? _____	how often? _____
<input type="checkbox"/> scintigraphy	when? _____	how often? _____
<input type="checkbox"/> others, which ones?	when? _____	how often? _____

---

Findings, examination results?

---

**Please provide us with a copy of the treatment and findings reports!**

What treatment methods/therapies have been performed so far or are recommended?

medication therapy (drug therapy), name? - dosage?

---

physical therapy

remedial gymnastics, physiotherapy from - to? \_\_\_\_\_

massages from - to? \_\_\_\_\_

chiropractic therapy from - to? \_\_\_\_\_

electrotherapy from - to? \_\_\_\_\_

hydrotherapy from - to? \_\_\_\_\_

occupational therapy, ergotherapy from - to? \_\_\_\_\_

others, which ones? from - to? \_\_\_\_\_

---

curing, spa treatment from - to? \_\_\_\_\_

orthopedic technical measures

insoles  heel increase

sole increase  orthopedic shoes

orthoses, prostheses  supporting bodice, corset

others, which ones?

---

surgical therapy, which one? when?

Are further diagnostic and/or therapeutic measures necessary, intended or recommended?

yes  no

If "yes", which ones?

Are you free of treatments and complaints?

yes     no

If “yes”, since when?

---

If “no”, which complaints do you have?

---

Which doctor can provide information? (Please provide name and address.)

---

---

Additional comments from the applicant or interested party:

---

---

---

---

---

---

---

---

---

---

---

---

**Notice:** Please let us have the discharge, examination, treatment and findings reports available to you for a short time (if possible, a copy).

**Declaration**

The information provided on the questions has been answered correctly and completely to the best of our knowledge. I am solely responsible for the correctness of the information, even if I did not fill out the declaration myself. I have observed the information on the “Consequences of the Violation of the Disclosure Obligation” in the application.

Place/date

Signature of the applicant resp. interested party