

Disability Claim Form – Chronic Back Pain

This **disability claim form** is designed specifically for individuals suffering from chronic back pain to facilitate the submission of their medical and personal information. It streamlines the process for obtaining necessary benefits by clearly outlining symptoms, treatment history, and functional limitations. Proper completion of this form ensures timely and accurate evaluation of disability status.

1. Personal Information

Full Name:

Date of Birth:

Contact Number:

Address:

2. Medical Information

Diagnosis:

e.g., Chronic lower back pain, herniated disc

Date Symptoms Began:

Describe Your Symptoms:

Pain location, severity, frequency, etc.

Treatment History (medications, therapies, surgeries):

3. Functional Limitations

Describe how back pain limits your daily activities, work, or mobility:

4. Physician Information

Physician's Name:

Physician's Contact:

Date of Last Medical Visit:

5. Additional Information

Other details or documents supporting your claim:

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