Attention Deficit-Hyperactivity Disorder

CLIENT NAME: _____ **Date:** _____

☐ Male ☐ Female Date of birth: _____ Height: _____' _____" Weight: _____

Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: _____ ☐ Use now Type of nicotine product: _____

Type of Coverage: ☐Term ☐UL ☐ Survivor ☐ Disability **Coverage Amount:** _____

Annual Income:_____ **Occupation/Job duties:** _____ **State of Residence:** _____

Anticipated Premium: _____

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who died by suicide?

If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of diagnosis of ADHD: _____
2. Current treatment; if taking medications, please list name of medication(s):

   _____
3. If taking medications, when was the last time the medication was changed: _____
4. Current severity of symptoms: ___ Mild ____ Moderate ____ Severe
5. Do symptoms cause impairment in functioning (e.g., problems at work, motor vehicle collisions, etc.):

   ____ Yes ____ No
6. Do you have any of the following psychiatric disorders (check all that apply):

   ___ Mood/anxiety disorder ___ Personality Disorder

   ___ Conduct or Oppositional Defiant Disorder ___ Suicidal thoughts/attempt

   ___ Substance use disorder (drugs or alcohol) ___ Other: _____
7. Have you ever been hospitalized or on disability for psychiatric reasons? ___ No ___ Yes; Date:_____
8. Do you have any other major health conditions? ___ No ____ Yes; please list below:

   _____

   _____
9. Please list current medications (including aspirin) with name, dose, and reason:

Name	Dose	Reason