NAILBA
NAILBA University

ALCOHOL USAGE

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. Does client presently consume alcoholic beverages? ☐ No ☐ Yes, If yes, please list

☐ Beer: Quantity _________ oz. per ☐ day ☐ week ☐ month (select one)

☐ Wine: Quantity _________ oz. per ☐ day ☐ week ☐ month (select one)

☐ Liquor: Quantity ________ oz. per ☐ day ☐ week ☐ month (select one)

2. What was the date of initial treatment or diagnosis? _________ / ________ / ________

3. Were there any relapses from sobriety/abstinence? ☐ No ☐ Yes; please provide details and dates

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4. Were there any legal problems (such as DUI) or other? ☐ No ☐ Yes; please provide details and dates

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_5. Have there been physical complications or additional psychiatric problems? ☐ No ☐ Yes; please provide details and dates, **including use of other substances such as marijuana, cocaine, opioids, etc.**

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6. Does client currently participate in a group such as Alcoholics Anonymous? ☐ No ☐ Yes

(Accurate) Name of Medication	Dosage	Reason

7. Please list current medications (accurate name, dosage, and reason):

8. What is client's: Martial status: __________________________

Occupation: ____ Length of employment: ____________________

9. Are there any other health issues? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

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