ANXIETY DISORDERS

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: _____

2. ☐ Generalized anxiety disorder ☐ Panic disorder

   ☐ Obsessive compulsive disorder ☐ Post-traumatic stress syndrome

   ☐ Agoraphobia ☐ Other anxiety disorder _____

3. Indicate the number of episodes and date of last episode/recovery: _____

4. Is client on any medications: ☐ No ☐ Yes; please provide name and dosage _____

5. Has client been hospitalized or seen in the emergency room for treatment of anxiety or other psychiatric illness? ☐ No ☐ Yes, please give dates and lengths of stay. _____

6. Does client have a history of any of the following associated conditions? (check all that apply)

   ☐ Depression ☐ Suicidal thought/attempt

   ☐ Substance abuse (alcohol or drugs) ☐ Other psychiatric disorder _____

7. Is the client currently working? ☐ No ☐ Yes (occupation)_____

8. Has any time been lost from work as a result of condition? ☐ No ☐ Yes; please give full details

_____

_____

_____

9. Please list current medications (including aspirin), (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

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

_____

_____

_____

