Autism Questionnare

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. Has any additional psychiatric disorder been diagnosed? __No __Yes
   If yes, please specify:_____

2. Has an intellectual disability or other developmental delay been diagnosed? __No __Yes
   If yes, please specify including severity:_____

3. Are there any physical impairments or other significant medical diagnoses (e.g., cerebral palsy, seizures)? __No __Yes
   If yes, please specify (if seizures, please include type and frequency):_____
   _____

4. Are activities of daily living (ADLs) or instrumental activities of daily living (IADLs) appropriate for client's age?
   a. ADLS= getting in/out of bed/chair and getting around, eating, dressing, bathing, using the toilet __Yes __No
      If no, please specify:_____
   b. IADLS= cooking, housecleaning, using the phone, driving, managing finances __Yes __No
      If no, please specify:_____

5. Is the client working or in school? __No __ Yes: Please give details (e.g., grade in school, any special classes/assistance; occupation): _____

6. Is your client able to live and function independently: ___ No ___Yes

7. Does your client take any medications? If so, please name them:
   _____
   _____