EATING 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. Please give the diagnosis: ☐ Anorexia nervosa ☐ Bulimia nervosa

2. Please indicate the number of episodes and date of last episode/recovery: _____

_____

3. Please note client's current _____ height _____ weight

4. Has weight remained stable for at least 1 year? ☐ No ☐ Yes; please give details

_____

_____

5. Has client been hospitalized for treatment of an eating disorder? ☐ No ☐ Yes; please give details

_____

_____

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

☐ Substance abuse (alcohol or drugs) Personality disorder

☐ Psychotic disorder Suicidal thought/attempt

☐ Depression Anxiety disorder

7. Is client on any medications? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

11. Does client have any other health issues? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____

