MENTAL HEALTH

(BIPOLAR DISORDER, SCHIZOPHRENIA, EATING DISORDERS, PANIC ATTACKS, PARANOIA, SUICIDE ATTEMPTS)

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. Describe client's condition. Give the diagnosis.

_____

_____

2. Date of first symptoms? _____

3. When did client last see doctor for this condition? _____

4. Has client been hospitalized ☐ No ☐ Yes; (list all)

Date: _____ _____

Date: _____ _____

5. Is client currently employed? ☐ No ☐ Yes

6. Has condition interfered with work? ☐ No ☐ Yes, If so, how long? _____

7. Is client disabled? ☐ No ☐ Yes; please give details

_____

_____

8. List all medications client is taking. (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

9. When was the last medication adjustment made?

Details _____

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

_____

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