



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: _____ Reason: _____

Date: _____ Reason: _____

5. Is client currently employed? No Yes

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

7. Does the client receive disability benefits for this condition? No Yes

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 of changes including date/reason for last change: _____

10. Have any other treatments been tried in the past (e.g., ketamine, TMS, ECT, etc.)? Please provide details including dates: _____

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