

## **ANXIETY DISORDERS**

CLIENT NAME:	CLIENT NAME:			Date:	
☐ Male ☐ Female Date of birth:	ht:'				
<b>Tobacco Use:</b> □ Never used □ Totally stopped Date stopped: □ Use now Type of nicotine product:					
Type of Coverage: ☐ Term ☐ UL ☐ Survivor Type of Coverage: ☐ Term ☐ UL ☐ Survivor UL					
Coverage Amount: Anticipated Premium:					
FAMILY HISTORY  Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed 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 Amou	unt	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: $\square$ No $\square$ 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? $\square$ No $\square$ 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? $\square$ No $\square$ Yes (occupation)					
8. Has any time been lost from work as a result of condition? $\square$ No $\square$ 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					