Schizophrenia Questionnaire

Name: ______________________________ Date of Birth: _________________________

Height: _____________ Weight: __________ Sex: M/F

Tobacco Usage: _______________________ Face Amount: ______________________

___Term 10 15 20 30 ___UL

1. When was the proposed insured first diagnosed? ____

2. Does the proposed insured experience any of the following?

___Apathy or lack of motivation ____ self-neglect (such as not bathing)
___Reduced or inappropriate emotion ____ Depression
___Substance Abuse ____ Bipolar disorder
____ Hallucinations ____ Delusions
___disorganized or confusing thoughts and speech.

3. Has the proposed insured ever been hospitalized as a result of this condition? _____Yes _____No
(If yes, please provide details):____

4. Has the proposed insured ever been disabled as a result of this condition? _____Yes _____No
(If yes, please provide the dates, and if currently on disability, their monthly disability income):
____
____

5. How is, the proposed insured, being treated for this condition? (Check all that apply)
A. Medication. (Please provide name, dosage, and frequency___________________________________
____
B. Therapy. (If yes, please provide frequency of visits): _____________________________________
____
C. Other. Please describe: ____
____

6. Have there ever been suicide attempts in relation to this condition? _____Yes _____No
(If yes, please provide details): ____
____
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