Asperger's Syndrome Questionnaire

Name: ________________________ Date of Birth: _______________________

Height: _________ Weight: _______ Sex: M/F

Tobacco Usage: ________________ Face Amount: _____________________

State of Residence: ____________________

___Term 10 15 20 30 ___UL

1. When was Asperger's Syndrome diagnosed? ____

2. Does the proposed insured experience any of the following? (Check all that apply)
___Problems with social skills
___Unusual preoccupations or rituals
___Limited range of interest's
___Exceptional skills/talents
___Eccentric or repetitive behaviors
___Communication difficulties
___Coordination problems
Details: ____

3. How is this condition being treated?
___Special education
___Speech, physical or occupational therapy
___Behavior modification
___Medication

4. Is the proposed insured taking any medication for this condition or any other? ___Yes ___No
(If yes, please provide the name, dosage, and frequency of all medications): ____________________
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