Cerebral Palsy 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 diagnosed with cerebral palsy? _____

2. What form of cerebral palsy has the proposed insured been diagnosed with?
___Dyskinetic ___Ataxic ___Spastic

3. Which of the following symptoms does the proposed insured experience? (Check all that apply)
___ Abnormal sensations and perceptions ___ Skin irritation ___ Dental Problems
___ Accidents due to muscle control/strength ___ Infection ___ Long term illnesses

4. Has the proposed insured experienced any of the following complications? (Check all that apply)
___ Joint Problems ___Bowel and Bladder Problems ___ Choking
___Acid Reflux ___ Slowed Growth

6. Is the proposed insured disabled as a result of this condition? ___Yes ___No

5. Is the proposed insured taking any medication? ___Yes ___No
(If yes, please provide name, dosage, and frequency): _____
_____
_____
_____

BSI (800) 229-9020 Local (301) 540-8484 Fax (301) 540-8787