Psychiatric Condition 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. What specific condition has the proposed insured been diagnosed with?
___Depression ___Anxiety ___Bipolar Disorder ___Schizophrenia
___Post Traumatic Stress ___Obsessive Compulsive Disorder
___Other (Please describe): ____

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

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4. Has the proposed insured ever been disabled as a result of this condition? _____Yes _____No
If yes, please describe):

____
____

5. How is the proposed insured being treated for this condition?

____ Medication (Please provide name, dosage and frequency):
____
____ Therapy (If yes, please provide frequency of visits):
____
____ Other (please describe):____

6. Have there ever been suicide attempts in relation to this condition? ______Yes ______No
(If yes, please describe):

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