Post-Traumatic Stress Disorder Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. When was the proposed insured first diagnosed with post-traumatic stress disorder? _____

2. Does the proposed insured experience any of the following symptoms? (Check all that apply.)

___ Reliving the event	___ Anxiety	___ Panic attacks
___ Psychosis	___ Difficulty sleeping	___ Outbursts of anger or irritability
___ Difficulty concentrating	___ Fear for your safety	___ Other: _____

3. Has the proposed insured ever been hospitalized as a result of this condition? ___ Yes ___ No
   If yes, provide details: _____
   _____

4. Has the proposed insured ever been disabled as a result of this condition? ___ Yes ___ No
   If yes, what is the monthly disability income? _____

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

   ___ Medication Name, dosage & frequency: _____
   ___ Therapy Frequency of visits: _____
   ___ Other: _____

6. Has the proposed insured every attempted suicide? ___ Yes ___ No

7. Does the proposed insured have any history of substance abuse? ___ Yes ___ No
   If yes, provide details: _____
   _____

8. Is the proposed insured currently taking any medication(s)? ___ Yes ___ No
   If yes, provide name, dosage and frequency of medication(s) _____
   _____
   _____

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