Schizophrenia 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 Schizophrenia? _____

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

___ Apathy or lack of motivation
___ Reduced or inappropriate emotion
___ Substance abuse ___ Bipolar disorder
___ Hallucinations
___ Disorganized or confusing thoughts and speech
___ Self-neglect (such as not bathing)
___ Depression
___ Delusions
___ 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, provide dates and monthly disability income: _____
_____

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

___ Medication Name, dosage and frequency: _____
___ Therapy Provide frequency: _____
___ Other: _____

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

7. 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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