# Tourette's Syndrome 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? _____

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

   ___ Simple motor tics involving only one muscle group
   ___ Complex motor tics involving a series of movements or muscle groups
   ___ Simple vocal tics involving simple sounds
   ___ Complex vocal tics involving words, phrases and sentences

3. Has the proposed insured ever suffered from any of the following? (Check all that apply.)

   ___ Depression Dates: _____ Details: _____
   ___ Attention Deficit Disorder Dates: _____ Details: _____
   ___ Obsessive Compulsive Disorder Dates: _____ Details: _____

4. How is the proposed insured being treated? _____
   _____

5. Is the proposed insured disabled as a result of this condition? ___ Yes ___ No
   If yes, provide details: _____
   _____

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

**FAX or E-MAIL to Donna Winterstine at 301-355-0429 / dwinterstine@bsibroker.com**