Post Traumatic Stress Disorder 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 symptom does the proposed insured experience?

___Reliving the event ___Anxiety ___Panic attacks
___Difficulty Sleeping ___Difficulty concentrating ___Fear for your safety
___Outbursts of anger or irritability ___Psychosis

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

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4. Has the proposed insured ever been disabled as a result of this condition? _____Yes _____No
(If so, what is their monthly disability income)? ____

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. Has the proposed insured ever attempted suicide? _____Yes _____No
(If yes, please describe):

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7. Does the proposed insured have any history of substance abuse? _____Yes _____No
(If yes, provide details):

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8. Is the proposed insured taking any medication for this condition or any other? _____Yes _____No
(If yes, please provide the name, dosage, and frequency of all medications):

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