

# ANXIETY DISORDERS

**CLIENT NAME:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Male  Female Date of birth: \_\_\_\_\_ Height: \_\_\_\_\_' \_\_\_\_\_" Weight: \_\_\_\_\_

**Tobacco Use:**  Never used  Totally stopped Date stopped: \_\_\_\_\_  Use now Type of nicotine product: \_\_\_\_\_

**Type of Coverage:**  Term  UL  Survivor **Type of Coverage:**  Term  UL  Survivor UL

**Coverage Amount:** \_\_\_\_\_ **Anticipated Premium:** \_\_\_\_\_

## FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?  
**If yes, use separate sheet to provide this information, including age of onset and date of death**

PROPOSED INSURED'S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Date of diagnosis: \_\_\_\_\_

2.  Generalized anxiety disorder  Panic disorder  
 Obsessive compulsive disorder  Post-traumatic stress syndrome  
 Agoraphobia  Other anxiety disorder \_\_\_\_\_

3. Indicate the number of episodes and date of last episode/recovery: \_\_\_\_\_

4. Is client on any medications:  No  Yes; please provide name and dosage \_\_\_\_\_

5. Has client been hospitalized or seen in the emergency room for treatment of anxiety or other psychiatric illness?  No  Yes, please give dates and lengths of stay. \_\_\_\_\_

6. Does client have a history of any of the following associated conditions? (check all that apply)  
 Depression  Suicidal thought/attempt  
 Substance abuse (alcohol or drugs)  Other psychiatric disorder \_\_\_\_\_

7. Is the client currently working?  No  Yes (occupation) \_\_\_\_\_

8. Has any time been lost from work as a result of condition?  No  Yes; please give full details  
 \_\_\_\_\_  
 \_\_\_\_\_

9. Please list current medications (including aspirin), (accurate name, dosage, and reason):

(Accurate) Name of Medication	Dosage	Reason

10. Are there any other health issues? (additional questionnaires may be required)  No  Yes; please give details  
 \_\_\_\_\_  
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