



## Attention Deficit Disorder Questionnaire

Name: \_\_\_\_\_

Date of Birth: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Sex: M/ F

Tobacco Usage: \_\_\_\_\_  
\_\_\_\_Term 10 15 20 30 \_\_\_\_UL

Face Amount: \_\_\_\_\_

1. When was the proposed insured first diagnosed? \_\_\_\_\_

2. What specific condition has the proposed insured been diagnosed with?

\_\_\_\_Attention Deficit Disorder

\_\_\_\_Attention Deficit Hyperactivity Disorder

3. Has the proposed insured ever been hospitalized as a result of this condition? \_\_\_\_Yes \_\_\_\_No

(If yes, please provide details):

\_\_\_\_\_  
\_\_\_\_\_

4. Has the proposed insured ever been disabled as a result of this condition? \_\_\_\_Yes \_\_\_\_No

(If yes, 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. Is the proposed insured taking medications for this condition or any other? \_\_\_\_Yes \_\_\_\_No

(If yes, please provided name of medication, dosage, and frequency) \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_