



## 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)

\_\_\_\_\_

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):

\_\_\_\_\_

\_\_\_\_\_

7. Does the proposed insured have any history of substance abuse? \_\_\_\_Yes \_\_\_\_No  
(If yes, provide details):

\_\_\_\_\_

\_\_\_\_\_

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):

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_