



Psychiatric Condition 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 specific condition has the proposed insured been diagnosed with?

___Depression ___Anxiety ___Bipolar Disorder ___Schizophrenia

___Post Traumatic Stress ___Obsessive Compulsive Disorder

___Other (Please describe): _____

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

4. Has the proposed insured ever been disabled as a result of this condition? _____Yes _____No
If yes, please describe):

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. Have there ever been suicide attempts in relation to this condition? _____Yes _____No
(If yes, please describe):
