Disability & Life Insurance Questionnaire

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Client Information

Name:_____
Date of Birth:_____
State You Live In:_____
Gender:_____
Occupation:_____
How Long Employed In Occupation:_____
How Many Hours / Wk Do You Work?_____
Gross Salary (if employee) or Net Income (if self-employed):_____

Health Conditions / Information

Height and Weight:_____ Tobacco Use No If last 5yrs, when quit?_____
Have You Lost or Gained More Than 10 Pounds Las 12 Months? No If Yes, How Much_____
Do You Use Marijuana Or Any Drug Use? No Have You Had A DUI/DWI? No Any Felonies or Misdemeanors? No
Do You Engage In Any Hazardous Activity Such As Scuba Dividing, Sky Diving, Bungee, Rock Climbing, etc? No
In The Past 5 Years Have You Had Any Insurance Rated, Modified, Or Declined? No If Yes, Why?_____

Have You Ever Been Diagnosed, Treated, Or Been Given Medical Advice For Any Of the Following Health Conditions:
Back, Neck, Knees, Shoulders, Hips, Wrists, Other Body Parts, Arthritis, or Fibromyalgia? No
High Blood Pressure, Chest Pain, Heart Attack, Stroke, Or Other Disease/Disorder of Heart, Veins, Arteries? No
Diabetes or pre-diabetes; Glandular diseases such as thyroid? No Any Cancer, Cysts, Polyp, Tumors? No
Migraines, Seizures, Paralysis? No Multiple Sclerosis, Muscular Dystrophy, Or Any Neurological Condition? No
Asthma, Sleep Apnea, Chronic Bronchitis, Emphysema, Or Any Other Disease/Disorder Of Lungs/Respitory? No
Anxiety, Depression, Bipolar, Schizophrenia, Fatigue, or Any Other Emotional/Nervous Disorder? No
Irritable Bowel, Ulcers, Colitis, Hepatitis, Cirrhosis, OR Any Disease/Disorder of Liver, Stomach, Intestines, Pancreas No
Any disorder/disease of the eyes, ears, nose, throat, or skin? No
Any kidney problems, bladder, breast problems, or reproductive organ problems? No
Any Miscarriages Or Troubled Pregnancies/Child Births? No Do you see a Chiropractor? No
Any tests or recommended surgeries or treatments which have NOT been completed? No
Are you disabled, in a wheelchair, need a walker, or need help with basic daily activities like dressing and bathing? No
What medication do you take? _____

Any “Yes”, please describe here: