Depression Questionnaire

Submit This Form with your application for better informed underwriting

Client Information

Client Name:				
DOB:	**Gender**	**Height**	**Weight**	**Marital Status**
Occupation & Length of Employment:				
Tobacco Use	Never Used	Totally Stopped		Current User
		Date Stopped		**Type Used**
Type of Coverage	Term	UL	Survivor	**Amount $**

Essential Information

1	Date of Diagnosis		Number of episodes	
			Date of last episode	
2	Has client been hospitalized for psychiatric treatment?	☐ Yes ☐ No	*If yes, give dates and lengths of stay*	
3	List current medications (accurate name, dosage and reason)			
4	Does client have a history of the following associated conditionals (check all that apply – additional questionnaires maybe required	☐ Personality Disorder	☐ Suicidal (thought or attempt)	
		☐ Psychotic Disorder	☐ Substance Abuse Alcohol or Drugs – require questionnaire	
	If Other Psychiatric Disorder – give details	☐ Other – *details*		
5	Is the client currently working	☐ Yes ☐ No	Has time been lost from work as a result of condition?	☐ Yes ☐ No — *If yes provide details*
6	Does the client have any other health issues	☐ Yes ☐ No	If yes provide details:	