Drug 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 Initial Treatment or Diagnosis		If client an active member of a drug use recovery group?	☐ Yes ☐ No	*If yes, how long?*
2	Has client every joined and then left a drug use recovery group	☐ Yes ☐ No	*If yes, give reason*		
3	What drug(s) were used or abused? (name of drug and dates of usage)				
4	Were there any relapses from sobriety / abstinence	☐ Yes ☐ No	*If yes, please list dates*		
5	List current medications (accurate name, dosage and reason)				
6	Has client every been convicted of any drug-related activity?	☐ Yes ☐ No	*If yes, please give detail*		
7	Have there been physical complications or additional psychiatric problems? Are there any other health issues?	☐ Yes ☐ No	*If yes provide details:*		