Eating Disorders 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	Type of diagnosis	☐ Anorexia Nervosa ☐ Bulimia Nervosa	Indicate number of episodes and date of last episode / recovery	
2	Has weight remained stable for at least 1 year	☐ Yes ☐ No	*If yes, give details*	
3	Has client been hospitalized for treatment of an eating disorder?	☐ Yes ☐ No	*If yes, please give dates*	
4	List current medications (accurate name, dosage and reason)			
5	Does client have a history of any of the following associated conditions? (check all that apply	Substance abuse (alcohol / drugs)		Personality disorder
		Psychotic disorder		Suicidal thought/attempt
		Depression		Anxiety disorder
6	Does the client have any other health issues	☐ Yes ☐ No	*If yes provide details:*	