Anxiety 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	List Date of First Diagnosis		
2	Generalized Anxiety Disorder		Panic Disorder
	Obsessive Compulsive Disorder		Post-Traumatic Stress Syndrome
	Agoraphobia		Other:
3	Indicate Number of Episodes		Date of Last Episode/Recovery
4	Is Client on any medications	☐ Yes ☐ No	If yes, Name of medication, dosage and reason
5	Has Client been hospitalized or seen in the emergency room for treatment of anxiety or other psychiatric Illness?	☐ Yes ☐ No	If yes, provide dates and lengths of stay
6	Does the client have a history of any of the following associated conditions (check all that apply)		
	Depression		Other Psychiatric Disorders:
	Suicidal thought/attempt		
	Substance abuse (alcohol or drugs)		
7	Is the client currently working	☐ Yes ☐ No	
8	Does the client have any other health issues?	☐ Yes ☐ No	If yes, provide details

Submit form to Don Boozer & Associates

Don Boozer & Associates
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