# Mental Health Questionnaire - Tentative offers obtained are not binding and could be subject to change – Final offers are subject to formal application and review of all required age/face requirements, paramedical requirements and review of complete medical records.

Agent/Advisor Name: _____
Proposed Insured: _____ Date Of Birth: _____ Gender: Male☐ or ☐Female
Build: Height_____ Weight_____ Any Weight Loss In Last Year? If so how much _____
Product Desired: Term ☐ Guarantee UL☐ Index UL☐ Whole Life☐Survivorship Life ☐
Face Amount Desired: Option 1 $_____ Option 2 $_____ Option 3$_____
Maximum Premium Tolerance Per Year: _____
Has Client Ever Used Any Form Of Nicotine? No ☐ Yes ☐
Type: ☐ Cigarettes ☐ Cigars ☐ Pipe ☐ Chew ☐ Patch ☐ Nicorette Gum ☐ E-Cigarette ☐ Vape
Frequency: _____ Date Last Used_____
Current Alcohol Use: Type_____ Number of Drinks: _____ Per _____Day ____Week Date Last Used: _____

1) What was your date of diagnosis? _____ Your age at onset? _____
2) Please select the condition(s) that you have had symptoms of, been diagnosed with or received treatment for?
   ☐Anxiety including generalized anxiety, panic or phobic disorder ☐Suicidal thought/attempt
   ☐Depression including major depression, dysthymia ☐ Schizophrenia or other psychotic disorder
   ☐Eating Disorder including anorexia nervosa, bulimia ☐ Manic depressive illness, bipolar disorder
   ☐Post Traumatic Disorder (PTSD) ☐Stress, sleeplessness, chronic tiredness ☐Personality disorder
   ☐Attention Deficit or Hyperactivity disorder (ADD/ADHD) ☐Alcohol or other substance abuse or addiction
   ☐ Conduct disorder or oppositional defiant disorder ☐Other: _____
   _____
3) When did you first experience symptoms?
   _____
   _____
   _____
4) Do you continue to experience symptoms? ☐Yes ☐No If No; when did you last experience any symptoms of this condition(s)?
   _____
   _____
   _____
5) Has the cause of this condition(s) been identified? ☐Yes ☐No If yes; provide details
   _____
   _____
6) Are you currently undertaking treatment for or have you ever undertaken treatment for this condition?
   ☐Yes ☐No If yes; provide details below

| Type of Treatment | Date Commenced | Date Ceased (if applicable) |
|---|---|---|
| ☐ Medication | | |
| Name & Dosage: | | |
| Name & Dosage: | | |
| Name & Dosage | | |
| ☐Counselling | | |
| ☐Cognitive Behavior Therapy (CBT) | | |
| ☐Other- Please provide full details of treatment below | | |
| | | |
| | | |
| | | |
| | | |

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7) Have you ever had any recurrences of this condition or suffered from or had symptoms of a similar condition? ☐Yes ☐No If yes; provide details and approximate dates

_____

_____

_____

8) Have you ever been admitted to the emergency room or hospital as a result of this condition(s), or any other mental or nervous disorder or condition? ☐Yes ☐No If yes; provide dates, details and length of admission

_____

_____

_____

9) Have you ever had suicidal thoughts, and/or attempted suicide? ☐Yes ☐No If yes; provide complete details

_____

_____

_____

10) Have you ever had time off work, or are you limited in your ability to work or perform you daily activities as a result of this condition? ☐Yes ☐No If yes; provide completed details

_____

_____

_____

11) Are you currently on disability for this condition? ☐Yes ☐No If yes; provide complete details, dates and duration

_____

_____

12) If minor, is the minor in regular class for age? ☐Yes ☐No If No; provide details

_____

_____

13) Is there family history of heart disease or cancer, or mental health disorders or suicide? ☐Yes ☐No If yes; provide details including relationship to yourself, age of onset, type and current age or date of death

_____

_____

14) Do you exercise three or more times per week on a regular basis? ☐Yes ☐No If yes; provide details

_____

_____

15) Have you made any lifestyle changes to improve your overall health? ☐Yes ☐No If yes; provide details

_____

_____

16) Are you being treated for any other medical conditions? If yes; provide details

_____

_____

17) Please list all other current medications, dosages and what condition the medication is treating

_____

_____

_____

**Please use additional pages if needed**

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