

DEPRESSION QUESTIONNAIRE

CLIENT: NAME _____ / M F / DOB _____ AGE _____ / HT _____ WT _____ / STATE _____

AMT. REQUESTED \$ _____ / MAX. ANNUAL PREMIUM \$ _____ / TYPE OF INS. UL TERM YRS. LVL _____

TOBACCO USE NO YES, TYPE _____ / REPLACEMENT YES NO / CURRENT ANN. PREM. \$ _____

LAST LIFE INSURANCE APP. YEAR _____ COMPANY _____ ACTION _____

OCCUPATION _____ / MARITAL STATUS SINGLE MARRIED WIDOWED DIVORCED

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

1. CLIENT HAS BEEN DIGNOSED AS:

- HAVING DEPRESSION
 BEING MANIC DEPRESSIVE (BIPOLAR)

2. HAS CLIENT EVER ATTEMPTED SUICIDE?

- NO YES, PLEASE DETAIL:

MONTH _____ YEAR _____

MONTH _____ YEAR _____

3. HAS CLIENT EVER BEEN HOSPITALIZED FOR DEPRESSION?

- NO YES, PLEASE DETAIL:

MONTH _____ YEAR _____

MONTH _____ YEAR _____

4. DURING THE PAST 12 MONTHS, HAS THE CLIENT MISSED WORK DUE TO DEPRESSION?

- NO YES, PLEASE DETAIL NUMBER OF OCCASIONS AND TIME MISSED:

5. IS CLIENT CURRENTLY TAKING MEDICATION FOR DEPRESSION?

- NO YES, PLEASE DETAIL TYPE AND DOSAGE:

6. IS CLIENT CURRENTLY SEEING OR HAS HE/SHE SEEN A MENTAL HEALTH THERAPIST?

- NO NOT CURRENTLY YES

IF YES OR NOT CURRENTLY, PLEASE DETAIL HOW OFTEN, FOR HOW LONG, AND THE DATE OF THE LAST VISIT:

7. IS CLIENT CURRENTLY RECEIVING, OR IN THE PAST RECEIVED, DISABILITY BENEFITS DUE TO DEPRESSION OR OTHER DISABILITY?

- NO YES, PLEASE DETAIL START AND END DATES:

START: MONTH _____ YEAR _____

END: MONTH _____ YEAR _____

- YES, CLIENT IS STILL GETTING BENEFITS

8. LIST ANY OTHER ILLNESSES OR IMPAIRMENTS (COMPLETE ANY OTHER QUICK QUOTE FORMS THAT MAY APPLY) ALONG WITH ALL MEDS AND VITAMINS TAKEN (INCLUDE DOSAGE AND FREQUENCY:

