

PARALYSIS AND SPINAL CORD INJURY 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

FAMILY HISTORY - AGE, IF STILL LIVING: FATHER _____ MOTHER _____ SIBLING 1 _____ SIBLING 2 _____ SIBLING 3 _____

IF ANY DECEASED GIVE RELATION, AGE AND CAUSE, OF EACH _____

DRIVING RECORD - # OF VIOLATIONS IN PAST 3 YEARS _____ / # OF DUI / RECKLESS DRIVING PAST 5 YEARS _____

DO YOU EXERCISE 3 OR MORE TIMES PER WEEK? NO YES, DETAILS _____

DATE OF LAST MEDICAL CHECKUP _____ / DATE OF LAST EKG _____ AND RESULTS _____

LAST BLOOD PRESSURE READING (RESULTS) _____ / _____ / ARE YOU TREATED FOR BLOOD PRESSURE NO YES

LAST CHOLESTEROL READING, HDL READING (RESULTS) _____, _____ TREATED FOR CHOLESTEROL NO YES

AGENT: NAME _____ PHONE _____ FAX _____

ADDRESS _____ CITY _____ ST _____ ZIP _____

LUMBROSACRAL SPINE _____

1. WHAT CAUSED THE PARALYSIS?

TRAUMA – GIVE DETAILS AND DATE OF OCCURRENCE:

SURGERY – GIVE DETAILS INCLUDING REASON FOR SURGERY AND DATE OF OCCURRENCE:

STROKE OR CEREBRAL VASCULAR ACCIDENT

OTHER – PLEASE GIVE DETAILS:

2. PLEASE NOTE CURRENT LEVEL OF FUNCTION:

- INCOMPLETE PARAPLEGIA
 COMPLETE PARAPLEGIA
 INCOMPLETE QUADRIPLÉGIA
 COMPLETE QUADRIPLÉGIA

3. IF PARALYSIS FROM INJURY OR TRAUMA, AT WHAT SPINAL CORD LEVEL (LIST SPECIFIC VERTEBRAE IF AVAILABLE, C7-8, FOR EXAMPLE):

CERVICAL SPINE _____

THORACIC SPINE _____

4. HAVE ANY OF THE FOLLOWING OCCURRED (CHECK ALL THAT APPLY):

- PNEUMONIA
 SKIN ULCERS
 URINARY TRACT INFECTION
 KIDNEY IMPAIRMENT
 DEPRESSION

5. ARE THERE ANY CURRENT SYMPTOMS OR COMPLICATIONS (CHECK ALL THAT APPLY):

- NORMAL BLADDER FUNCTION, OR NEEDS ASSISTANCE
 NORMAL BOWEL FUNCTIONS, OR NEEDS ASSISTANCE
 USES CANE ONLY
 WHEEL CHAIR BOUND
 BED BOUND
 NEEDS ASSISTANCE EATING
 NEEDS ASSISTANCE TO COMMUNICATE

6. IS TREATMENT CURRENTLY PRESCRIBED?

NO YES, DETAILS _____

7. 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): _____