Cerebral Palsy Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. What type of Cerebral Palsy has been diagnosed? ___ Dyskinetic ___ Ataxic ___ Spastic

2. When was the proposed insured diagnosed? _____

3. Which of the following symptoms does the proposed insured experience? (Check all that apply.)

___ Abnormal sensations and perceptions
___ Skin irritation
___ Dental problems
___ Accidents due to muscle control/strength
___ Infection
___ Long term illnesses
___ Other: _____

3. Has the proposed insured experienced any of the following complications? (Check all that apply.)

___ Joint problems
___ Choking
___ Slowed growth
___ Bowel and bladder problems
___ Acid Reflux

4. Has the proposed insured ever been disabled as a result of this condition? ___ Yes ___ No
If yes, provide details: _____
_____

5. Is the proposed insured taking any medication(s)? ___ Yes ___ No
If yes, provide name, dosage and frequency of medication(s): _____
_____
_____
_____
_____

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