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Chronic Fatigue Syndrome Questionnaire

Agent Name: ______________________________ Phone #:______________________ E-mail:___________________________

Client Name: ______________________________ Date of Birth: __________________ Sex: ___Male / Female__ _______

Height: ___________ Weight: __________ State: ___________ Smoker: __Y / N__ Face Amount: __________________

Type of Insurance: ___ Universal Life ___ Whole Life ___ Survivorship ___ Term (# of years _______)

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1. When was the proposed insured diagnosed with Chronic Fatigue Syndrome? ____________________________________

2. Does the proposed insured suffer from any of the following symptoms? (Check all that apply.)

   ___ Forgetfulness, memory loss, confusion, difficulty concentrating
   ___ Sore throat
   ___ Tender lymph nodes in the neck or armpits
   ___ Muscle pain
   ___ Joint pain
   ___ New headaches
   ___ Un-refreshed sleep
   ___ Fatigue that lasts more than 24 hours
   ___ Other: ____

3. Has the proposed insured ever received any of the following treatments?

   ___ Medication Date and details: ____
   ___ Exercise Program Date and details: ____
   ___ Cognitive behavioral therapy Date and details: ____

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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