United
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Post-Traumatic Stress Disorder 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 first diagnosed with post-traumatic stress disorder? ____________________________
2. Does the proposed insured experience any of the following symptoms? (Check all that apply.)

   ___ Reliving the event ___ Anxiety ___ Panic attacks
   ___ Psychosis ___ Difficulty sleeping ___ Outbursts of anger or irritability
   ___ Difficulty concentrating ___ Fear for your safety ___ Other: ________________________

3. Has the proposed insured ever been hospitalized as a result of this condition? ___ Yes ___ No
   If yes, provide details: ____
   ____

4. Has the proposed insured ever been disabled as a result of this condition? ___ Yes ___ No
   If yes, what is the monthly disability income? ____

5. How is the proposed insured being treated for this condition?

   ___ Medication Name, dosage & frequency: ____
   ___ Therapy Frequency of visits: ____
   ___ Other: ____

6. Has the proposed insured every attempted suicide? ___ Yes ___ No
7. Does the proposed insured have any history of substance abuse? ___ Yes ___ No
   If yes, provide details: ____
   ____

8. Is the proposed insured current taking any medication(s)? ___ Yes ___ No
   If yes, provide name, dosage and frequency of medication(s) ____________________________________
   ____
   ____

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