# Cerebral Palsy 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. **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: ____________________________

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3. **Has the proposed insured experienced any of the following complications?** (Check all that apply.)
   - ___ Joint problems
   - ___ Bowel and bladder problems
   - ___ Choking
   - ___ Acid Reflux
   - ___ Slowed growth

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

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