

# Underwriting Questionnaire

## Chronic Pain



Producer Name \_\_\_\_\_ Phone \_\_\_\_\_ Date \_\_\_\_\_

Client Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Male  Female Face Amount \_\_\_\_\_ Max Premium \$ \_\_\_\_\_ /yr.

Term  Permanent Has the client ever used any form of tobacco (cigarettes, cigars, pipe, snuff, etc.)?  Yes  No

Frequency \_\_\_\_\_ Date of last use \_\_\_\_\_ Type \_\_\_\_\_

What medical condition or impairment is the source of the chronic pain \_\_\_\_\_ Date of onset \_\_\_\_\_

If due to injury, describe how the client was injured and symptoms experienced as a result \_\_\_\_\_

Is narcotic pain medication taken  Yes  No If yes, advise name of the medication(s), dosage(s) and frequency taken \_\_\_\_\_

Is the client prescribed medical marijuana  Yes  No If yes, advise prescription details to include how much and how often it is used and method (smoked, ingested, drops, etc.) \_\_\_\_\_

Has the client ever used more medication than what is prescribed  Yes  No If yes, provide details \_\_\_\_\_

Will the client be on narcotic pain medication long term or is this use temporary \_\_\_\_\_ If temporary, when does he/she expect to be off medication \_\_\_\_\_

How often does the client see his/her doctor or pain management specialist \_\_\_\_\_

Is the client significantly impaired in a normal day-to-day activities  Yes  No If yes, advise what limitations the client has \_\_\_\_\_

On a pain scale of 1 to 10, how does the client describe his/her level of pain (circle a number) very mild  
1 2 3 4 5 6 7 8 9 10 severe

Does the client attend support groups and/or chronic pain rehabilitation program such as physical therapy or other  Yes  No

If yes, provide details \_\_\_\_\_

What is the client's occupation \_\_\_\_\_ Is the client currently working  Yes  No

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Is the client on disability  Yes  No If yes, date he/she went on disability\_\_\_\_\_

Is the disability going to be  permanent or  temporary If temporary, advise approximate duration of disability\_\_\_\_\_

Has the client ever had a history of anxiety, depression, or other mental health condition  Yes  No If yes, provide full details

Has the client ever had a history of drug or alcohol abuse  Yes  No If yes, provide full details\_\_\_\_\_

Does the client currently drink alcohol  Yes  No If yes, provide amount per sitting and frequency of use\_\_\_\_\_

Does the client use any recreational drugs  Yes  No If yes, advise type and frequency of use\_\_\_\_\_

Name of Medication (prescription or otherwise)	Dates Used	Quantity Taken	Frequency Taken

List any other major health problems the client has: