ANXIETY DISORDER QUESTIONNAIRE

Rohrer & Associates

Insured's Name: DOB: State: Sex: M / F

Height: Ft. In. Weight: Face Amount:

Tobacco use in the past 5 years: No Yes Details:

Producer: State: Phone: E-mail:

Proposed Insured please answer the following:

1. Please select the diagnosis (circle all that apply):
   - generalized anxiety disorder
   - panic disorder
   - obsessive compulsive disorder
   - post-traumatic stress syndrome
   - agoraphobia
   - other anxiety disorder:

2. Please indicate the number of episodes and date of last episode/recovery:

3. Are you on any medication(s)? No Yes
   Name(s) and dosage(s):

4. Have you been hospitalized or seen in the emergency room for treatment of anxiety or other psychiatric illness? No Yes
   Details:

5. Do you have a history of any of the following associated conditions (circle all that apply)?
   - depression
   - suicidal thought/attempt
   - substance abuse (alcohol or drugs)
   - other psychiatric disorder

6. Do you have any other major health problems (i.e. cancer, etc.)? No Yes
   Details:

Additional Information (please use reverse side for additional space):

Date: _____ Insured's Signature: _____