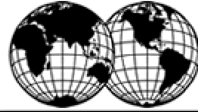

BROKERAGE GROUP INTERNATIONAL, LLC

# Anxiety Questionnaire

Broker Name: ______________________________ Date: ________________________

Phone: ___________________________________ Fax: ________________________

E-Mail: __________________________________

Address/City/State/Zip: ______________________________________________

**CLIENT INFORMATION**

Name: ___________________________________________ ☐ M ☐ F

Date of Birth: ________________ Height: ___________ Weight: _______________

Occupation: ___________________________________________________________

Insurance Amount ______________ Insurance Type: ☐ Term ☐ Universal Life ☐ Whole Life

Death Benefit: _________________ ☐ Second to Die ☐ Variable

Have you ever used tobacco or nicotine products? ☐ Yes ☐ No

If yes, what type of product did you use? ☐ Cigarettes ☐ Cigar ☐ Pipe ☐ Other

**ANXIETY INFORMATION**

1. Describe your condition. ___________________________________________
   a. Give the diagnosis, if known. ______________________________________
      ______________________________________________________________
2. Date of first symptoms? ___________ ______________________________
3. When did you last see the doctor for this condition? _________________
4. Have you been hospitalized?
   a. ☐ Yes ☐ No
   b. When (list all)? __________________________________________________
5. Are you taking any medication?
   a. ☐ Yes ☐ No
   b. Name of RX? ______________________________________________________
6. Are you employed? ☐ Yes ☐ No
7. Have mental conditions interfered with your work?
   a. ☐ Yes ☐ No
   b. If so, how long? __________________________________________________
8. Are you disabled? ☐ Yes ☐ No
9. Additional Comments? _______________________________________________

______________________________________________________________________

______________________________________________________________________