Chronic Fatigue Syndrome Questionnaire

Agent Name: _____ Phone #: (_____) _____

Agent E-mail: _____

Client Name: _____ Date of Birth: _____

Sex: Male / Female Height: _____ Weight: _____ State: _____ Smoker: Yes / No

Face Amount: $_____ Type of Insurance: ___ UL ___ WL ___ SUL ___ Term (# of years _____)

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1. When was the proposed insured diagnosed with Chronic Fatigue Syndrome? _____

2. Does the proposed insured suffer from any of the following symptoms? (Check all that apply.)

___ Forgetfulness, memory loss, confusion, difficulty concentrating
___ Sore throat
___ Tender lymph nodes in the neck or armpits
___ Muscle pain
___ Joint pain
___ New headaches
___ Un-refreshed sleep
___ Fatigue that lasts more than 24 hours
___ Other: _____

3. Has the proposed insured ever received any of the following treatments?

___ Medication Date and details: _____

___ Exercise Program Date and details: _____

___ Cognitive behavioral therapy Date and details: _____

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

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

FAX or E-MAIL to Donna Winterstine at 301-355-0429 / dwinterstine@bsibroker.com