NEUROLOGICAL DISORDER QUESTIONNAIRE

Reset Form

Name	Date of Birth (dd/mmm/yy)	Application #

1.

Age at onset:	Date of last episode:		
Symptoms / Diagnosis:			
Are you currently experiencing any symptoms?	○ Yes ○ No		
Are you performing activities of daily living (bathing, dressing, eating) with:	○ Little or no difficulty	○ Moderate difficulty	○ Extreme difficulty
Are you working or doing housework with:	○ Little or no difficulty	○ Moderate difficulty	○ Extreme difficulty
Are you able to walk/stand with: or walker	○ Little or no difficulty ○ Bedridden	○ Moderate difficulty	○ Use of a wheelchair
What degree of muscle strength do you have?	○ Little or no difficulty	○ Moderate difficulty	○ complete loss
Degree of bladder / bowel function?	○ Little or no difficulty	○ partial loss	○ complete loss
If you have difficulties, please give details below.			

2. Have you ever had problems with: ○ Vision ○ Swallowing ○ Breathing ○ Numbness ○ Bladder infections ○ Weakness / Fatigue ○ Other

If you have had problems, please give details below.

Name address & phone number of medical advisor(s) consulted:

Details of any medication taken (type, dose, frequency):	Still taking medication	Date medication was stopped
	○ Yes ○ No	
	○ Yes ○ No	
	○ Yes ○ No	
	○ Yes ○ No	

Date & results of last CT scan or MRI: ○ never had one

Other tests done including date & results:

3. Have you ever been hospitalized for this condition? ○ Yes ○ No If yes, please give details below.

Have you ever required emergency treatment for this condition? ○ Yes ○ No If yes, please give details below.

Have your job duties or leisure activities been affected in any way or have you lost any time from work because of your condition? ○ Yes ○ No If yes, please give details below.

I hereby declare that the above answers are complete and true, and agree that they shall form part of my application for the policy requested.

Signature of Applicant	Signature of Witness	Date (dd/mmm/yy)
X	X	

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