Alcohol Questionnaire

Producer Name: _____ **Contact Phone:** _____

Client Name: _____ Age:_____ DOB:_____

Sex: _____ Height:_____ Weight: _____

Client's Premium Tolerance (what do you need in order to place the case)? [required]

_____

Any Tobacco/Nicotine Use in the Past 5yrs? ☐ Yes ☐ No If Yes, Type/Frequency/Date Last Used? _____

_____

Face Amount: _____ Product: _____

Any Parent or Sibling Diagnosed with Cancer, Heart Disease, Stroke, Kidney Disease or Diabetes? ☐ Yes ☐ No

If Yes, Provide Age at Diagnosis, Age at Death, or Age if Still Living:

_____

If Your Client Has a History of Alcohol Abuse, Please Answer the Following:

1. Does your client presently consume alcoholic beverages?

   ☐ Beer How many per occasion? _____ Frequency? _____
   ☐ Wine How many per occasion? _____ Frequency? _____
   ☐ Liquor How many per occasion? _____ Frequency? _____

2. Has the client ever consumed substantially more than at present? If so, please provide details:

3. Why did the client change their drinking habits?

4. Has your client ever had or been made aware of any of the following?

   ☐ Elevated liver enzymes ☐ Positive alcohol marker ☐ Blackouts ☐ Withdrawal seizures
   ☐ Family/Friends' concern over drinking habits
   ☐ Legal or employment challenges due to alcohol use (Provide details) _____
   ☐ Driving under the influence charges (Provide dates) _____
   ☐ Medical complications related to alcohol (Provide details)

   ☐ Use of other substances such as illicit drugs or prescription drugs (Provide details)

5. Has the client ever consulted a physician or received treatment or advice or been hospitalized due to their alcohol use? If so, provide dates, hospitals, treatment centers and physicians' names and addresses:

6. Has the client ever had a relapse from sobriety/abstinence? If so, provide dates and details:

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7. Does your client currently participate in a group such as Alcoholics Anonymous? ☐ Yes ☐ No

If So, How Often? _____

8. Has your client ever been prescribed medication such as Antabuse, Campral or Nalmafene to treat their alcohol addiction?
If so, please provide name of medication and date of last use: _____

9. Please List All Prescription and Over the Counter Medications & Dosages Currently Being Taken:

Prescription, Over the Counter or Vitamins	Dosages	Reason

10. Does the Client Have Any Other Known Medical Condition? ☐ Yes ☐ No If Yes, Please Provide Details:

11. Please Provide any Additional Details that You Feel are Important: