NAILBA
NAILBA University

EATING DISORDERS

CLIENT NAME: ______________________________ **Date:** ______________
☐ Male ☐ Female Date of birth: __________ Height: _____’ _____” Weight: __________
Tobacco Use: ☐ Never used ☐ Totally stopped Date stopped: __________ ☐ Use now Type of nicotine product: __________
Type of Coverage: ☐ Term ☐ UL ☐ Survivor **Type of Coverage:** ☐ Term ☐ UL ☐ Survivor UL
Coverage Amount: ______________ **Anticipated Premium:** ______________

FAMILY HISTORY

Has proposed insured had a parent, brother or sister who had cancer, diabetes, stroke, heart or kidney disease or who committed suicide?
If yes, use separate sheet to provide this information, including age of onset and date of death

PROPOSED INSURED’S EXISTING INSURANCE			
Full Name of Company	Face Amount	Year Issued	Is Policy to be Replaced?

1. Please give the diagnosis: ☐ Anorexia nervosa ☐ Bulimia nervosa

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

3. Please note client’s current __________ height __________ weight

4. Has weight remained stable for at least 1 year? ☐ No ☐ Yes; please give details
____
____

5. Has client been hospitalized for treatment of an eating disorder? ☐ No ☐ Yes; please give details
____
____

6. Does client have a history of any of the following associated conditions? (Please check all that apply.)
☐ Substance abuse (alcohol or drugs) Personality disorder
☐ Psychotic disorder Suicidal thought/attempt
☐ Depression Anxiety disorder

7. Is client on any medications? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

11. Does client have any other health issues? (additional questionnaires may be required) ☐ No ☐ Yes; please give details
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