Return to - jim@uswolfe.com or Fax to 815-377-3556

HEADACHE/MIGRAINE/CONCUSSION QUESTIONNAIRE

Insured's Name:		DOB:	State:	Sex: M / F
Height: Ft. In.	Weight:	Face Amount:		
Tobacco use in the past 5 years: No Yes	Details:			
Producer:	State:	Phone:	E-mail:	

Proposed Insured please answer the following:

1. What is your actual diagnosis?

2. When did your headaches first start?

3. When was your last headache?

4. How often do your headaches occur?

5. The duration of your headaches are (please circle):
   Intermittent Continuous Brief Prolonged

6. Which part of your head is usually affected (please circle all that apply)?
   Front Back Top Sides

7. Are your headaches associated with certain foods such as chocolate, coffee, or MSG? Yes No
   Details:

8. Indicate below any other associated symptoms (please circle all that apply):

Vision (vision fields or double vision)	Numbness or tingling	Muscle weakness
Unsteadiness of limbs or staggering	Nausea, vomiting	Undue sleepiness
Dizziness, hearing loss	Kidney Disorder	High blood pressure
Have fits or explosive behavior		

9. Is there any relationship between your headaches and any of the below (please circle all that apply)?
   Allergies Medications Nervous tension Menstrual cycle

10. Have you had any special diagnostic testing done for your headaches? Yes No
    Details:

11. Are you taking any medications? Yes No
    Name(s) and dosage(s):

12. Name(s), address(es) & phone number(s) of your physician(s) and date last consulted:

Additional Information (please use reverse side for additional space):

Date: _____ Insured's Signature: _____