

# ARTHRITIC QUESTIONNAIRE

Please fax back to IPA at 781 643-2775

Name: \_\_\_\_\_ DOB: \_\_\_\_\_

1. When was the proposed insured first diagnosed with arthritis? \_\_\_\_\_  
\_\_\_\_\_
2. What type of arthritis does the proposed insured have? \_\_\_\_\_  
\_\_\_\_\_
3. Does the client have to use any assistance due to their condition? \_\_\_\_\_  
\_\_\_\_\_
4. Who is the attending physician? \_\_\_\_\_  
\_\_\_\_\_
5. What type of medication does the proposed insured take? \_\_\_\_\_  
\_\_\_\_\_
6. Has the client had any type of surgeries due to arthritis? \_\_\_\_\_  
\_\_\_\_\_
7. Is the client able to care for self? \_\_\_\_\_  
\_\_\_\_\_
8. Is the client able to work? \_\_\_\_\_  
\_\_\_\_\_
9. Are there any other impairments involved with the proposed insured?  
\_\_\_\_\_  
\_\_\_\_\_

Agent Name: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Fax No: \_\_\_\_\_

Date: \_\_\_\_\_ E-mail Address: \_\_\_\_\_

Please circle the associate you work with. Russ, Rhonda, Leo