Client Health Questionnaire

CLIENT NAME	DATE OF BIRTH	TOBACCO USE	HEIGHT	WEIGHT
#1:		☐ NO ☐ YES		
#2:		☐ NO ☐ YES		

HEALTH STATUS & HISTORY

IN THE PAST 10 YEARS HAVE YOU: RECEIVED MEDICAL ADVICE, TREATMENT, BEEN DIAGNOSED OR CONSULTED WITH A HEALTH PROFESSIONAL FOR ANY OF THE FOLLOWING CONDITIONS?

	CLIENT 1	CLIENT 2
Alcoholism or Drug Addiction	☐	☐
Alzheimer's	☐	☐
Amputation	☐	☐
Asthma, COPD or Emphysema	☐	☐
Atrial Fibrillation	☐	☐
Brain Disorder	☐	☐
Cancer, Leukemia or Lymphoma	☐	☐
Chronic Bronchitis	☐	☐
Congestive Heart Failure	☐	☐
Depression or Mental Disorder	☐	☐

	CLIENT 1	CLIENT 2
Diabetes	☐	☐
Disabling back condition	☐	☐
Epilepsy / Seizures	☐	☐
Fainting Spells	☐	☐
Heart Attack, Surgery or Angioplasty	☐	☐
Hodgkin's Disease	☐	☐
Injury due to fall / balance	☐	☐
Joint Replacement Surgery	☐	☐
Multiple Sclerosis	☐	☐
Osteoporosis	☐	☐

	CLIENT 1	CLIENT 2
Paralysis	☐	☐
Parkinson's / Tremors	☐	☐
Rheumatoid Arthritis	☐	☐
Spine Condition	☐	☐
Strokes / TIAs	☐	☐
Tuberculosis (TB)	☐	☐
Other condition causing crippling / disability	☐	☐
Other conditions causing limited motion	☐	☐
Other conditions requiring adaptive devices	☐	☐
Other: _____	☐	☐

PLEASE PROVIDE DETAILS BELOW FOR ANY QUESTIONS ANSWERED YES

Do you have any scheduled doctor appointments, surgery, therapy or treatment?

Details for any prescription & over-the-counter medications; including the name, dosage and frequency.

Authorization To Disclose Personal Medical Information

Under applicable state & federal laws, including the Health Insurance Portability and Accountability Act (HIPAA), I give 6m Group/INERTIA / Advisor Services Group, and its agents/representatives access to and use of my protected health information for the purposes of the underwriting or administration of insurance coverage on my behalf. The information used in accordance with this authorization may be redisclosed by INERTIA, and may no longer be protected by federal and state privacy laws.

- *By signing this form, I agree to the release, disclosure and sharing of of my medical information by 6M Group & INERTIA and its agents and I relieve them from all liability having to do with that disclosure. This authorization will expire 24 months from the date of your signature. (Only valid for one year in CT, GA, IL, MA, MN, NC, NJ, OH and OR). I am entitled to a copy of this authorization form and digital copy of this authorization is as valid as the original.*
- *I have the right to revoke this authorization, in writing, at any time but the revocation will not have any effect on any actions taken in reliance on this authorization or relating to the use or disclosure of the protected health and non-health information taken before receipt of the revocation notice.*

Signatures of insured, applicant, annuitant, claimant or legal representative	Date	Applicable State(s)	Phone Number
_____	_____	_____	_____