



Risk Assessment– Drug Questionnaire

Agent Name:	
Address:	
Email:	
Phone:	
Applicant Name:	
Date Of Birth:	
Sex:	Male Female
Height/Weight:	
Occupation:	
Death Benefit:	
Type of Product:	Term UL Whole Life 2nd To Die
Has Client EVER Used Tobacco? YES NO	Date of Last Use:
Specify All Types of Nicotine Used:	Cigarettes Cigar Pipe Other:
Has Client Been Treated for Drug Abuse? YES NO	Date of Treatment: Name of Facility:
Is Client Member of: AA NA CA?	Date Joined:
How often client attend?	
Has Client Ever Used? YES NO	Circle All That Apply: Heroin, Morphine, Demerol, Methadone, Codeine, Percodan, Dilaudid
Has Client Ever Used? YES NO	Circle All That Apply: Amytal, Phenobarbital, Seconal, Nembutal, Pentobarbital
Has Client Ever Used? YES NO	Circle All That Apply: Marijuana, Hashish, Cannabis

Has Client Ever Used? YES NO	Circle All That Apply: Benzedrine, Dexedrine, Methedrine, Preludin
Has Client Ever Used? YES NO	Circle All That Apply: Cocaine, Crack
Has Client Ever Used? YES NO	Circle All That Apply: LSD, DMT, Mescaline, Peyote, Psilocybin, PCP
Has Client Ever Used? YES NO	Circle All That Apply: Librium, Valium, Quaalude, Dalmane, Placidyl
If Yes to any above indicate type, quantity, frequency of use & dates of use:	Details:
Were any of the above prescribed by a physician? YES NO	Details:

Additional Comments:

This Questionnaire Must Accompany Your Formal Application.

FSA Preliminary Assessment: _____
