LTC Health Questionnaire

SIMPLICITY GROUP

General Information

Advisor Name: _____ Tel. #: _____

Email: _____ State: _____

Client Name: _____ Spouse Name (if married): _____

Date of Birth: _____ Spouse's Date of Birth: _____

Pre-Screening Health Statement - Part A

	Client	Spouse (if applicable)
1. Within the past two years have you been confined to a nursing home, assisted living center, received or been advised to receive hospice care, been advised that you have a terminal illness or need assistance with: bathing, eating, dressing, toileting, transferring into and out of bed, chair, or wheelchair and/or maintain continence?	☐ Yes ☐ No	☐ Yes ☐ No
2. Are you currently hospitalized, bedridden or use medical devices such as: wheelchair, walker, dialysis machine, oxygen equipment, respirator, stair lift, chair lift, motorized scooter or taking medications Aricept, Exelon, Reminyl or Namenda?	☐ Yes ☐ No	☐ Yes ☐ No
3. Have you ever been diagnosed by a member of the medical profession as having AIDS, HIV, or ARC disorders, or tested positive for antibodies for the AIDS virus?	☐ Yes ☐ No	☐ Yes ☐ No
4. If under the age of 65, is there any reason you are not physically and mentally capable of active employment or are you currently receiving or have received within the past five years social security disability income benefits?	☐ Yes ☐ No	☐ Yes ☐ No
5. Have you ever been diagnosed, treated, tested positive for, or been given professional medical advice for: Alzheimer's disease, dementia, memory loss, multiple sclerosis, muscular dystrophy, ALS (Lou Gehrig's disease) Parkinson's disease, down syndrome, organ transplant (other than kidney) or active cancer?	☐ Yes ☐ No	☐ Yes ☐ No

Pre-Screening Health Statement - Part B

Client: _____ **Height:** _____ **Weight:** _____

In the past 5 years, is there a history of:

- ☐ Diabetes
- ☐ Depression
- ☐ Uncontrolled High Blood Pressure
- ☐ Cancer
- ☐ Leukemia
- ☐ Heard Disease
- ☐ Congestive Heart Failure
- ☐ Organ Failure/Disease
- ☐ Heart Attack
- ☐ Cardiomyopathy
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Chronic Obstructive Lung Disease (COLD)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Stroke

IF ABOVE CHECKED PLEASE PROVIDE DETAILS ON NOTES PAGE

Other: _____

CLIENT	DOSE	FREQUENCY	REASON

Spouse: _____ **Height:** _____ **Weight:** _____

In the past 5 years, is there a history of:

- ☐ Diabetes
- ☐ Depression
- ☐ Uncontrolled High Blood Pressure
- ☐ Cancer
- ☐ Leukemia
- ☐ Heard Disease
- ☐ Congestive Heart Failure
- ☐ Organ Failure/Disease
- ☐ Heart Attack
- ☐ Cardiomyopathy
- ☐ Amyotrophic Lateral Sclerosis (ALS)
- ☐ Chronic Obstructive Lung Disease (COLD)
- ☐ Chronic Obstructive Pulmonary Disease (COPD)
- ☐ Stroke

IF ABOVE CHECKED PLEASE PROVIDE DETAILS ON NOTES PAGE

Other: _____

CLIENT	DOSE	FREQUENCY	REASON

Monthly Income:

Type	Client Income	Spouse Income
Social Security		
Gross Wages		
Pensions		
Other		
Total		

Do you rely on IRA Income for living expenses? ☐ **Yes** ☐ **No**

Notes