

NEUROLOGICAL DISORDER QUESTIONNAIRE - PHYSICIAN

T0	BE FILLED BY THE PHYSICIAN					
Name of the Life Insured						
App	lication Number					
PLEASE ANSWER EACH QUESTION AND PROVIDE PARTICULARS WHEREVER REQUIRED						
1.	Which neurological disorder does/did your patient suffer from?					
2.	When did the symptoms first occur?					
3.	Please describe the presenting symptoms:					
4.	If there was more than one episode, please give dates, duration and severity of each episode:					
5.	When were the last symptoms seen? What was the frequency of the episodes?					
6.	Please describe the current status of the disorder, including any improvement or worsening of the initial symptoms:					
7.	Impact of condition:					
	a) Is there, or has there been any restriction or limitation on their ability to work?	Yes	No			
	If 'Yes', please provide details, including duration of any time off- work in the last five years:					
	b) Does your patient use a wheelchair or any other form of mobility aid?	Yes	☐ No			
	If 'Yes', please provide details:					

	c) Does your patient require any form of assistance with activities around the house, such as dressing, preparing foo household work or bathing? If 'Yes', please provide details:	d, Yes	□ No
8.	Has the patient been referred for specialist opinion or investigation?	Yes	☐ No
	If 'Yes', please provide full details including name, address and specialty of doctor and dates and nature of any investigation. If still awaiting an appointment, please advise when do you expect to see the patient:	ations carried o	ut or to be carried
9.	Please provide details of the current treatment, including names and dosages of each medication:		
10.	. If these drugs or dosages have been changed in the last two years, please provide details, including why:		
	Please state about the patient's reflexes: elbow, wrist, knee, ankle & planter reflexes:		
	Please confirm about tone, power and co-ordination of motor system:		
11.	Are there any issues with posture and gait? (If yes, please describe): Please comment on any other relevant features or co-morbidities or any other illness or habits, which may influence the	_	No the condition:
	Signature:		
	Please print name and add clinic stamp		