# Neurological disorder questionnaire - Applicant

Full name:

Application number:

1. Please state the precise diagnosis, if known.

2. When did symptoms first occur?

3. Do you still have symptoms? Yes ☐ No ☐

If YES, are they constant, variable, improving, or progressively worsening?

If NO, when did you last have any symptoms?

4. Regarding your symptoms:

a) Vision - Have you ever experienced:

- Loss of or blurring of vision? Yes ☐ No ☐
- Double vision or diplopia? Yes ☐ No ☐
- Flashing lights? Yes ☐ No ☐
- Any other visual disturbance? Yes ☐ No ☐

If YES to any of the above, please provide full details, including severity and when affected.

b) Speech and hearing - Have you ever experienced:

- Slurring or difficulty of speech? Yes ☐ No ☐
- Tinnitus (buzzing or ringing) in the ear? Yes ☐ No ☐
- Difficulty in hearing? Yes ☐ No ☐

If YES to any of the above, please provide full details, including severity and when affected.

c) Weakness, paralysis or abnormal sensation - Have you ever experienced:

- Numbness or loss of sensation? Yes ☐ No ☐
- Pins and needles, tingling or paraesthesia? Yes ☐ No ☐
- Limb weakness or loss of muscle power? Yes ☐ No ☐
- Difficulty walking, loss of balance, unsteadiness or ataxia? Yes ☐ No ☐

If YES to any of the above, please provide full details, including severity and when affected.

d) Bowel and bladder – Have you ever experienced:

- Altered urinary frequency or incontinence? Yes ☐ No ☐
- Altered stool frequency or incontinence? Yes ☐ No ☐

If YES to any of the above, please provide full details, including severity and when affected.

e) Others – Have you ever experienced:

- Vertigo or dizziness? Yes ☐ No ☐
- Facial pain or paralysis? Yes ☐ No ☐
- Loss of consciousness? Yes ☐ No ☐
- Recurrent headaches? Yes ☐ No ☐
- Any other neurological or sensory symptoms? Yes ☐ No ☐

If YES to any of the above, please provide full details, including severity and when affected.

5. Have you been referred for specialist opinion or investigation? Yes ☐ No ☐
If YES, please provide full details including name, address and speciality of doctor and dates, nature and results of any investigations carried out or to be carried out. If you are awaiting an appointment, please advise when you expect to be seen.

6. Please provide details of your current treatment, including names and dosages of each medication. If these drugs or dosages have been changed in the last two years, please advise details including why.

7. Severity:

a) Is there, or has there been, any restriction or limitation on your ability to work? Yes ☐ No ☐
If YES, please provide details, including duration of any time off work in last 2 years.

b) Has the condition caused you to change or reduce your non-occupational activities, e.g. sport, hobbies, mode of transport, etc? Yes ☐ No ☐
If YES, please provide details.

c) Do you use a wheelchair or any other form of mobility aid, e.g. stair lift? Yes ☐ No ☐
If YES, please provide details.

d) Do you require or receive any form of assistance with basic activities around the house, such as dressing, preparing food, housework, bathing? Yes ☐ No ☐
If YES, please provide details.

e) Are you eligible for any form of disability benefit or support from the state, from insurance or from an employer? Yes ☐ No ☐
If YES, please provide details including type of benefit and amount received.

8. Please provide any additional information on your condition which you feel will be helpful in processing your application.

I declare that the answers I have given are, to the best of my knowledge, true and that I have not withheld any material information that may influence the assessment or acceptance of this application.
I agree that this form will constitute part of my application for insurance and that failure to disclose any material fact known to me may invalidate the contract.

Signature of applicant

Date