

Cerebral Palsy Questionnaire

Claim Administrator:
Consociate • Dansig
Attn: Underwriting
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9088

Group name: _____

Employee name: _____

Dependent name (if condition is for dependent) _____

Age: _____ Height: _____ Weight: _____

1. When was condition originally diagnosed? _____

2. Are there any physical disabilities? Yes or No If yes, what are they? _____

3. Is there any mental incapacity associated with this condition? _____

4. What problems or symptoms have been experienced with this condition? _____

Last time it happened? _____

5. What treatment was received and when? Include any surgery, hospitalization or medication/how often and what amount. _____

6. How often does the person visit the doctor's office or medical clinic for this condition _____ Do they attend physical/speech therapy? _____ If yes, what is the schedule? _____

7. Have future tests, surgery or treatment been scheduled, prescribed or recommended? If yes, please explain: _____

8. Have there been any complications such as incontinence, difficulty with feeding, swallowing, etc. ? _____

Please be advised that you may be required to submit medical records.

Employee signature: _____ Date: _____

