



Long-Term Care Planning Assessment

Client Name	Sex	Date of Birth	Nicotine Usage (Yes or No & Type)	Height	Weight
#1: _____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	_____
#2: _____	<input type="checkbox"/> M <input type="checkbox"/> F	_____	_____	_____	_____

Health Status & History

In the past 10 years, provide information about ALL conditions have you received medical advice, treatment, diagnosis, or consultation?

	#1 or #2	Provide details for <u>any and all</u> conditions, with information about the physician(s), surgery, treatments, therapy, planned follow-ups, or medications taken (including over-the-counter), with the drug name, reason, dosage, and frequency.	
Cancer (other than skin) *			
Cardiac/Coronary/A-Fib Issues *			
Diabetes *			
Alzheimer's, MS, or Parkinson's		<u>CLIENT #1</u>	<u>CLIENT #2</u>
Back conditions/problems of ANY kind		_____	_____
Depression or Mental Disorder		_____	_____
Chronic Pain or Disabling condition		_____	_____
COPD / Breathing Issue / C-PAP Usage		_____	_____
Epilepsy / Seizures		_____	_____
Joint Replacement Surgery		_____	_____
Osteoporosis / Osteopenia		_____	_____
Rheumatoid Arthritis / Autoimmune		_____	_____
Strokes / TIAs		_____	_____
Condition limiting motion		_____	_____
OTHER: _____		_____	_____

* Provide Cancer, Cardiac and Diabetic details below

Cancer	Type, location, and date of diagnosis: _____ Stage/Grade/Metastasis: _____
	Dates/details of treatment and/or surgery: _____
	Any recurrence and date of last follow-up: _____
Cardiac, A-Fib & Coronary	Date of diagnosis/Onset of chest pain: _____ Number of involved vessels: _____
	Dates and details of treatment and/or surgery: _____
	Date, type, and results of last testing: _____
	Any symptoms since treatment/surgery: _____
Diabetes	Type: <input type="checkbox"/> I or <input type="checkbox"/> II Date of diagnosis: _____ Date/result of last A1c: _____
	Treatment: <input type="checkbox"/> Insulin <input type="checkbox"/> Diet <input type="checkbox"/> Medication Type and dosage: _____
	Which of the following conditions have also been diagnosed? <input type="checkbox"/> Retinopathy <input type="checkbox"/> Kidney Disease <input type="checkbox"/> Neuropathy <input type="checkbox"/> Hypertension <input type="checkbox"/> Insulin Reaction <input type="checkbox"/> Protein in Urine

Lifestyle and Family Dynamics

	CLIENT #1	CLIENT #2
Describe Your Build: Slim = 1 Athletic = 2 Muscular = 3 Oval/Pear = 4		
Ancestry: Europe = 1 Asia = 2 Africa = 3 India = 4 Latin America = 5 Middle East = 6 Other = 7 _____		
How many times do you exercise 30+ minutes in a given week?		
How many servings of fruits and vegetables do you have every day?		
How many alcoholic drinks do you consume each day?		
Where do you turn for emotional support? (Select all that apply) Self = 1 Spouse = 2 Family = 3 Friends = 4		
How many doctor/dentist visits do you have in a given year?		
Family History of Cancer? (Select all that apply) None = 1 Self = 2 Family = 3 Type: _____		
Family History of Alzheimer's or Dementia? (Select all that apply) None = 1 Self = 2 Family = 3		
Family History of Diabetes? (Select all that apply) None = 1 Self = 2 Family = 3		
Family History of Heart Disease? (Select all that apply) None = 1 Self = 2 Family = 3		
Family History of Stroke? (Select all that apply) None = 1 Self = 2 Family = 3		
Planned/Actual Age of Retirement and State To Live During Retirement (Example 68 - FL)		
How many parents or grandparents lived to at least age 85:		

Plan Funding:

<input type="checkbox"/> Non-Qualified \$ _____	<input type="checkbox"/> One-Time	<input type="checkbox"/> 5-Pay	<input type="checkbox"/> 10-Pay	<input type="checkbox"/> 20-Pay	<input type="checkbox"/> Lifetime / Annual
<input type="checkbox"/> Qualified \$ _____					
<input type="checkbox"/> Cash Value from an Annuity: \$ _____					
<input type="checkbox"/> Cash Value from Life Insurance: \$ _____					

Authorization To Disclose Personal Medical Information

Under applicable state & federal law, including the Health Insurance Portability and Accountability Act (HIPAA), I give your firm and its agents/representatives access to and use of my protected health information for the purposes of the underwriting or assessing your qualification for of insurance coverage. The information used in accordance with this authorization may be redisclosed by your firm and may no longer be protected by federal and state privacy laws.

By signing this form, I agree to the release, disclosure, and sharing of my medical information by your firm and its agents with only insurance carriers and their underwriters. I relieve them from all liability having to do with that disclosure. This authorization will expire 6 months from the date of your signature. I am entitled to a copy of this authorization form, and a digital copy of this authorization is as valid as the original.

I have the right to revoke this authorization, in writing, at any time, but the revocation will not have any effect on any actions taken in reliance on this authorization or relating to the use or disclosure of the protected health and non-health information taken before the receipt of the notice.

Signatures of the insured, applicant, or legal representative

Date

Applicable State(s)

Phone Number