

Impaired Risk Form: Please complete and use one of the following methods to submit your information:

1. Call number given below and submit your information via phone.
2. Scan and email info to email address given below.
3. Mail info to: Attn: Genyatto Brown, P.O. Box 2305, Dunn, NC 28335

**Agent / Agency:** \_\_\_\_\_ **Phone:** \_\_\_\_\_ **fax:** \_\_\_\_\_  
**Email address:** \_\_\_\_\_ **State:** \_\_\_\_\_

**Client Name:** \_\_\_\_\_ **M.** \_\_\_ **F** \_\_\_ **State:** \_\_\_\_\_ **DOB** \_\_\_\_\_  
**Height:** \_\_\_\_\_ **Weight:** \_\_\_\_\_ **Tobacco:** \_\_\_Y\_\_\_N **TYPE:** \_\_\_\_\_ **Insurance Amt:** \_\_\_\_\_

**Diabetes:** **Type I** \_\_\_ **Type II** \_\_\_ **When Diagnosed:** \_\_\_\_\_ **Oral med.** \_\_\_\_\_ **Insulin:** \_\_\_\_\_  
**If Insulin:** \_\_\_\_\_ **units per day** **A1c reading:** \_\_\_\_\_ **Approx. date:** \_\_\_\_\_  
**Impairments:** \_\_\_ **Eyes** \_\_\_ **Neuropathy** \_\_\_ **Amputations** \_\_\_ **Skin ulcerations** \_\_\_ **Protein in urine**

**Heart Disease:** **When diagnosed:** \_\_\_\_\_ **Heart Attack:** \_\_\_Y\_\_\_N **Mild or Mod.** \_\_\_\_\_  
**ByPass Surgery:** \_\_\_Y\_\_\_N **How many vessels:** \_\_\_\_\_ **AngioPlasty:** \_\_\_Y\_\_\_N **#Stents placed:** \_\_\_\_\_  
**Conditions preceding procedure:** \_\_\_ **Heart attack** \_\_\_ **Chest pain** \_\_\_ **Irreg. EKG** \_\_\_ **Extreme fatigue:** \_\_\_\_\_  
**Approx. Date of Last Stress Test:** \_\_\_\_\_

**Cancer:** **When Diagnosed:** \_\_\_\_\_ **Type:** \_\_\_\_\_ **Treatment:** \_\_\_\_\_  
**Prostate:** **Stage:** \_\_\_\_\_ **Gleason Score:** \_\_\_\_\_ **Current PSA reading:** \_\_\_\_\_  
**Skin Cancer:** **Type:** \_\_\_\_\_ **Stage:** \_\_\_\_\_ **Clark's level:** \_\_\_\_\_ (if Melanoma)  
**Breast Cancer:** **Stage:** \_\_\_\_\_ **Treatment:** \_\_\_\_\_ **Lymph Node:** \_\_\_Y\_\_\_N  
**Approximate date of last treatment:** \_\_\_\_\_ (NOTE: Secure Pathology Report if possible)

**Stroke:** **Date:** \_\_\_\_\_ **Cause:** \_\_\_\_\_ **Treatment:** \_\_\_\_\_  
**If Carotid Artery:** **Surgery:** \_\_\_Y\_\_\_N **If yes, Date:** \_\_\_\_\_ **Percent of blockage:** \_\_\_\_\_  
**Residuals:** \_\_\_Y\_\_\_N **Slurred Speech:** \_\_\_Y\_\_\_N **Loss or Restriction of Limb use:** \_\_\_Y\_\_\_N  
**Number of Strokes in past 24 months:** \_\_\_\_\_ **none** \_\_\_ **One** \_\_\_ **two or more**

**Depression:** **When diagnosed:** \_\_\_\_\_ **Situational:** \_\_\_ **BiPolar** \_\_\_ **Anxiety** \_\_\_ **PTSD** \_\_\_  
**Suicide attempts:?** \_\_\_Y\_\_\_N **Hospitalized?** \_\_\_Y\_\_\_N **If so, Date & how long:** \_\_\_\_\_  
**Currently seeing Therapist:** \_\_\_Y\_\_\_N **Frequency:** \_\_\_\_\_ **Last Visit:** \_\_\_\_\_  
**Currently able to work:** \_\_\_Y\_\_\_N

**Pain:** **Diagnosed:** \_\_\_\_\_ **Cause:** \_\_\_\_\_ **Location of pain:** \_\_\_\_\_  
**Treatment:** \_\_\_\_\_ **Medication(s):** \_\_\_\_\_

**Other Impairments (Describe with as much information as possible):** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**All Current Medications:** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_