VIVA Health Inc. Health Questionnaire
Follow up: Cerebral Palsy

Employee____________________ Group Name:________________

Proposed Insured______________ D.O.B.____________________

1. Describe the severity of the syndrome: mild moderate significant severe

2. How does the syndrome affect your activities of daily living? What activities require the assistance of another person?

3. Please list any equipment you have to help with your activities of daily living. e.g. wheelchair, braces, etc.

4. If you are of school age, do you regularly attend school? What is the name of the school?

5. If you are of working age, do you work full-time? Who is your employer? Describe job responsibilities.

6. Please give details of hospitalizations and/or surgeries during the past 5 years i.e. reason for admission, length of stay, name of hospital, dates.

7. Please give details of physician visits during the past 5 years. i.e. name/address, specialty, dates, reason for visit.

8. List any medications with dosage and frequency which you are currently taking.

9. What treatment are currently being administered. E.g. physical therapy, speech therapy, etc. Give details on frequency.

10. What is your physician's prognosis for future treatment/surgery?

Signature:____________________________ Date:__________________________