RESET

CROHN'S DISEASE

AGENT NAME: _____

CLIENT NAME: _____ **Date:** _____

1. Date of first diagnosis: _____

2. Blood in stools? ☐ Yes ☐ No

3. What type of treatment is client on?

☐ Diet

☐ Medication—if so, what? (accurate name, dosage, and reason)

(Accurate) Name of Medication	Dosage	Reason

4. How often does client have attacks? _____

5. Is condition asymptomatic? ☐ Yes ☐ No

7. Does client have any other health issues? (additional questionnaires may be required) ☐ No ☐ Yes; please give details

_____

_____

Save and Email Completed Form to: quotes@levelfourinsurance.com