

MENTAL HEALTH QUESTIONNAIRE

Name:

Policy Number:

Please indicate which of the following mental health condition/s you have had:

1.

a) Anxiety including generalized anxiety, panic or phobic disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
b) Eating disorder including anorexia nervosa or bulimia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
c) Depression including major depression or dysthymia	<input type="checkbox"/> Yes	<input type="checkbox"/> No
d) Bipolar disorder or manic depressive illness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
e) Alcohol or other substance abuse or addiction	<input type="checkbox"/> Yes	<input type="checkbox"/> No
f) Post-traumatic stress	<input type="checkbox"/> Yes	<input type="checkbox"/> No
g) Schizophrenia or any other psychotic disorder	<input type="checkbox"/> Yes	<input type="checkbox"/> No
h) Stress, sleeplessness, chronic tiredness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
i) Other (please describe): _____	<input type="checkbox"/> Yes	<input type="checkbox"/> No

2. Please describe your symptoms:

Symptoms	Date from	Date to

3. Has any reason for your condition been identified? Yes No
If yes, please provide details:

4. When was the condition diagnosed or when did you first experience symptoms?

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5. Have you had any recurrences of this condition/s? Yes No
If yes, please provide details:

Date from	Date to

6. Do you currently take any medication for this condition? Yes No
If yes, please provide details:

Name of medication	Dose	Frequency

7. Other than already stated above, have you taken any other medication in the past for this condition? Yes No
If yes, please provide details:

Name of medication or treatment	Dose	Frequency	Date last taken

8. Have you ever had any other treatment for this condition e.g. counseling, cognitive behavioral therapy, electroconvulsive treatment etc.? Yes No
If yes, please provide details:

Nature of treatment	Location	Date

9. Have you ever been admitted to a hospital or clinic for this condition? Yes No
If yes, please provide details:

Name of doctor, hospital or clinic	Address	Dates

10. Has any further treatment or investigation been discussed or contemplated? Yes No
If yes, please provide details:

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11. Please provide details regarding the doctors and/or specialists you see in relation to this condition:

Name of doctor, hospital or clinic	Address	Date of last consult

12. Have you ever taken time off work with this condition? Yes No
If yes, please provide dates and durations:

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13. Have your working duties ever been affected or restricted in any way? Yes No
If yes, please provide details including dates and durations:

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14. Please provide any additional information that you feel is important:

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Declaration

I confirm that the answers I have given are, to the best of my knowledge, true, and that I have not withheld any material information that may influence the assessment or acceptance of this application.

I agree that this form will constitute part of my application for insurance(s) and that failure to disclose any material fact known to me may invalidate my insurance(s).

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Name

x

Signature

/ /

Date