

Mental Health Questionnaire-By Medical Doctor

Name: _____

Policy Number: _____

Kindly obtain the relevant medical information from the named person below to best answer the following questions based on history and any available medical information done as relayed to you.

1. What diagnosis has been made?
Date: _____ (Month/year)
2. What symptom has your patient presented?

3. Are there any existing psychosocial stressors (e.g divorce, etc)?
 No
 Yes-please provide detail _____
4. What treatment was given?(Please give detail time period, Type medication, Dosage, Number sessions psychotherapy)
 Drug Therapy-Details _____
 Psychotherapy-Details _____
 Others-Details _____
5. Has the patient ever been hospitalized for this condition?
 No
 Yes-please provide detail _____
6. Is the patient compliant with the therapy prescribed?
 Yes
 No
7. Has the patient completed the therapy?
 No
 Yes
8. Did the patient ever express suicidal thoughts or attempt commit suicide?
 No
 Yes-Date/since when _____
9. Is your patient prone to any substance abuse, e/g alcohol, therapeutic or illicit drugs?
 No
 Yes-please provide detail _____
10. Does the patient's condition interfere to any degree with his/her ability to carry out his/her occupation?
 No
 Yes-please provide detail _____
11. What is the patient's current mental status?

Name of Doctor : _____

Signature of Doctor : _____

Clinic Rubber Stamp : _____

Dated : _____

Telephone No. : _____