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 ☐ Yes ☐ No
   b) Eating disorder including anorexia nervosa or bulimia ☐ Yes ☐ No
   c) Depression including major depression or dysthymia ☐ Yes ☐ No
   d) Bipolar disorder or manic depressive illness ☐ Yes ☐ No
   e) Alcohol or other substance abuse or addiction ☐ Yes ☐ No
   f) Post-traumatic stress ☐ Yes ☐ No
   g) Schizophrenia or any other psychotic disorder ☐ Yes ☐ No
   h) Stress, sleeplessness, chronic tiredness ☐ Yes ☐ No
   i) Other (please describe): _____ ☐ Yes ☐ 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? / /

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 to

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

Name of doctor, hospital or clinic	Address	Dates

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

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? If yes, please provide dates and durations: ☐ Yes ☐ No

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

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

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).

Name	Signature	Date
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