



Mental Health Questionnaire

Name:

Policy Number:

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?

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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

Name of treatment	Location	Date to

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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