PSYCHOLOGICAL QUESTIONNAIRE

Reset Form

Name	Date of Birth (dd/mmm/yy)	Application #

1. Do you or have you suffered from:

- ☐ Anxiety
- ☐ Panic / Phobias
- ☐ Depression
- ☐ Eating disorder
- ☐ Bipolar or manic depressive illness
- ☐ Post-traumatic stress disorder
- ☐ Schizophrenia or other psychotic illness
- ☐ Burn out
- ☐ Insomnia / Sleep problems
- ☐ Alcohol or substance abuse / addiction
- ☐ Other, please give details:

When did the first symptom occur?

What appeared to be the reason for your symptoms?

Have you had any relapses? If yes, please state date(s), treatment(s) and length of time for each:

Are you currently experiencing any symptoms? ◯ Yes ◯ No If yes, describe current symptoms:

If no, how long have you been symptom free?

Name address & phone number of medical advisor(s) consulted:

Was a diagnosis made? If so, please state:

Details of any medication taken (type, dose, frequency):	Still taking medication	Date medication was stopped
	◯ Yes ◯ No	
	◯ Yes ◯ No	
	◯ Yes ◯ No	
	◯ Yes ◯ No	

2. Have you ever been hospitalized for this condition? ◯ Yes ◯ No If yes, please give details below.

Are you or have you ever received outpatient psychotherapy/counselling? ◯ Yes ◯ No If yes, please give details below.

Have you received electroconvulsive therapy? ◯ Yes ◯ No If yes, please give details below.

Have you ever had any suicidal thoughts or attempts? ◯ Yes ◯ No If yes, please give details below.

Have your job duties or leisure activities been affected in any way or have you lost any time from work because of your condition?
◯ Yes ◯ No If yes, please give details below.

I hereby declare that the above answers are complete and true, and agree that they shall form part of my application for the policy requested.

Signature of Applicant	Signature of Witness	Date (dd/mmm/yy)
X	X	

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