

APPLICANT'S STRESS / ANXIETY / DEPRESSION QUESTIONNAIRE

NAME OF APPLICANT: _____ DATE OF BIRTH: _____

POLICY #: _____ REFERENCE #: _____

Please answer the following questions. Include as much information as you can. You **do not** need to take this form to a doctor.

1 When did your symptoms start? _____
Number of episodes? _____
Date: First episode: _____ Most recent episode: _____

2 What was the cause or diagnosis given to you by a doctor? _____

3 Have you ever required any time off work or hospitalization for your condition? Yes No
Date off work: _____ Duration: _____
Date of hospitalization: _____ Duration: _____

4 Have you ever required any medication for your condition? Yes No
Name: _____
Dosage: _____
Date prescribed: _____
How long did you take it? _____
Are you still taking medication? Yes No

5 Were you referred to a psychiatrist? Yes No
Psychiatrist's Name: _____
Address: _____
Frequency of consultations: _____ Date of last consultation: _____

6 Name of doctor or hospital that has all your records: _____
Address: _____

7 What is your current status (stable, resolved, still under treatment)? _____

I declare my answers and statements indicated above have been correctly recorded and to the best of my knowledge and belief, are complete and true.

Date _____ Signature _____