

Psychological or Nervous Disorder Questionnaire

First Name : _____ Last Name : _____
 Policy Number : _____ Date of Birth (DD/MM/YYYY): ____/____/____

1. In the last 10 years, have you been diagnosed with, treated for or had any symptoms or indication of any psychological, emotional or nervous disorder? Yes No
 If yes, please indicate the medical diagnosis and proceed with the following questions. If no, please date and sign at the bottom of the questionnaire. Medical diagnosis: _____
 Was any cause identified? Yes No
 If yes, please give details. _____

2. Please indicate which of the following apply to your condition, and provide us with further details :

<p>Symptoms</p> <input type="checkbox"/> Insomnia <input type="checkbox"/> Fatigue <input type="checkbox"/> Nervousness (anxiety) <input type="checkbox"/> Depressed mood <input type="checkbox"/> Suicidal thoughts <input type="checkbox"/> Suicide attempt(s) <input type="checkbox"/> Other (specify): _____ <p>Referral</p> <input type="checkbox"/> Therapy <input type="checkbox"/> Referral to a psychologist <input type="checkbox"/> Referral to a psychiatrist	<p>Details (dates and duration)</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>_____</p> <p>Details (dates, duration, name of physician)</p> <p>_____</p> <p>_____</p> <p>_____</p>
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3. Date you first experienced symptoms : _____

4. Frequency of symptoms (daily, weekly, monthly, etc.): _____

5. Date of your last symptoms: _____

6. Are you currently taking any medication for these conditions? If yes, please list the name of any medication. Yes No

7. Have you ever taken any medication for these conditions in the past, other than those listed in question 6? Yes No
 If yes, please list the name of the medication(s) and date(s) taken:

8. Was any hospitalization required for any of these conditions? Yes No
 If yes, dates and duration: _____

9. Was any time off work required for any of these conditions? Yes No
 If yes, dates and duration: _____

10. Do you consume alcohol or drugs (other than mentioned above)? Yes No
 If yes, please confirm if alcohol, drugs or both and your weekly consumption: _____

11. Do you have any pending consultation or treatment? Yes No
 If yes, please provide details (date, treatment, name of attending physician). _____

12. Name of personal physician: _____

I declare that the above information is true and complete and acknowledge that it shall form part of my insurance application with Assumption Life.

Signature of proposed insured (parent or legal guardian if a minor) _____ Date (DD/MM/YYYY) _____
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