La Capitale

PSYCHOLOGICAL DISORDERS QUESTIONNAIRE

Last name

First name

Date of birth: Year Month Day

Application or Contract No.

1 a) What is the nature of your psychological disorder?

- ☐ Adjustment disorder
- ☐ Anxiety (generalized anxiety, panic, mental distress or phobia)
- ☐ Attention deficit disorder with or without hyperactivity (ADHD)
- ☐ Bipolar disorder (maniac depression)
- ☐ Depression (major, seasonal or situational depression or dysthymia)
- ☐ Eating disorder (anorexia or bulimia nervosa)
- ☐ Post-traumatic shock (post-traumatic stress)
- ☐ Schizophrenia (psychosis or psychotic disorders)
- ☐ Stress (burnout, exhaustion, overwork or chronic fatigue)
- ☐ Suicide attempt(s): Year Month
- ☐ Other: _____

2 Date of diagnosis: Year Month

3 Date of first episode: Year Month Date of last episode: Year Month Number of episodes: _____

4 Name and mailing address of all physicians or other healthcare professionals consulted for this condition.

Name	Address	Date of consultation
		Year Month
		Year Month
		Year Month

5 Are you taking any medication for this condition? ◯ Yes ◯ No

If so, specify. _____

If not, have you ever done so? ◯ Yes ◯ No

If so, specify the medications, the reason and the cessation date. _____

Has your medication been adjusted in the last six months? ◯ Yes ◯ No

If so, specify. _____

6 Are you receiving or have you received complementary therapy from a physician, psychiatrist or psychologist? ◯ Yes ◯ No

If so, specify. _____

La Capitale Civil Service Insurer Inc.
625 Jacques-Parizeau St, Quebec QC G1R 2G5

La Capitale Financial Security Insurance Company
7150 Derrycrest Drive, Mississauga ON L5W 0E5

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7 Have you been hospitalized as a result of this condition? ◯ Yes ◯ No **If so,** specify.

Name of hospital	Address	Date of admission
		Year Month
		Year Month

8 Have you received other treatments (e.g. electroconvulsive therapy)? ◯ Yes ◯ No

If so, specify. _____

9 Have you ever had to go on disability leave because of this condition? ◯ Yes ◯ No

If so, specify the start date and length of each disability period.

Start date	Length (number of weeks)
Year Month	
Year Month	
Year Month	

10 Did you make a full recovery? ◯ Yes ◯ No **If so,** specify the date of the last symptoms. Year Month

11 Please provide all relevant additional information. _____

I hereby acknowledge and agree that the answers to the questions in this questionnaire are true and complete.

Signed at _____ on this _____ day of _____ 20 _____ .

X _____
Signature of proposed insured or of legal guardian, if the proposed insured is under age 18 in Quebec or under 16 in other provinces.

X _____
Signature of witness

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