

<input style="width: 95%; height: 20px;" type="text"/> Last name	<input style="width: 95%; height: 20px;" type="text"/> First name
Date of birth: <input style="width: 150px; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> Year Month Day </div>	<input style="width: 95%; height: 20px;" type="text"/> Application or Contract No.

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

<input type="checkbox"/> Adjustment disorder <input type="checkbox"/> Anxiety (generalized anxiety, panic, mental distress or phobia) <input type="checkbox"/> Attention deficit disorder with or without hyperactivity (ADHD) <input type="checkbox"/> Bipolar disorder (manic depression) <input type="checkbox"/> Depression (major, seasonal or situational depression or dysthymia) <input type="checkbox"/> Eating disorder (anorexia or bulimia nervosa)	<input type="checkbox"/> Post-traumatic shock (post-traumatic stress) <input type="checkbox"/> Schizophrenia (psychosis or psychotic disorders) <input type="checkbox"/> Stress (burnout, exhaustion, overwork or chronic fatigue) <input type="checkbox"/> Suicide attempt(s): <input style="width: 100px; height: 20px;" type="text"/> <div style="display: flex; justify-content: space-around; font-size: small;"> Year Month </div> <input type="checkbox"/> Other: _____
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2 Date of diagnosis:

Year
Month

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

Year
Month
Year
Month

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

Name	Address	Date of consultation
_____	_____	<input style="width: 100%; height: 20px;" type="text"/> Year Month
_____	_____	<input style="width: 100%; height: 20px;" type="text"/> Year Month
_____	_____	<input style="width: 100%; height: 20px;" type="text"/> 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. _____

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

Name of hospital	Address	Date of admission												
_____	_____	<table border="1"> <tr> <td> </td><td> </td><td> </td><td> </td><td> </td><td> </td> </tr> <tr> <td colspan="3">Year</td> <td colspan="3">Month</td> </tr> </table>							Year			Month		
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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)												
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Year			Month										

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

Year			Month		

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 _____ .

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

 _____
Signature of witness