Mental Health Questionnaire

Title | Surname

Given name(s)

Date of birth
/ /

1 Please indicate the conditions you have had or received treatment for?

- ☐ Anxiety including generalised anxiety, panic or phobia disorder
- ☐ Eating disorder including anorexia nervosa, bulimia
- ☐ Depression including major depression, dysthymia
- ☐ Manic depressive illness, bi-polar disorder
- ☐ Alcohol or other substance abuse or addiction
- ☐ Post traumatic stress
- ☐ Schizophrenia or any other psychotic disorder
- ☐ Stress, sleeplessness, chronic tiredness
- ☐ Other Please describe

2 Please describe your symptoms including the date they started and how long they lasted.

3 Has any reason for your condition been identified?

☐ No
☐ Yes

Please provide details

4 When was your condition first diagnosed? / /

5 Have you had any recurrences of this condition?

☐ No
☐ Yes

How many times? When? / /

6 Have you ever received any counselling or treatment for this condition? (eg medication, CBT, hospitalisation)

☐ No
☐ Yes ***Please provide details below***

Type of Treatment	Date Commenced	Date Ceased

7 Are you currently receiving treatment?

☐ No When did treatment cease? / /

☐ Yes Please provide details

8 Please provide the names and addresses of doctors you have consulted including the date first and last consulted.

Name

Address

State | Postcode

Date first consulted / /

Date last consulted / /

Question 8 continued …

Name

Address

State

Postcode

Date first consulted

/ /

Date last consulted

/ /

9 Has your condition ever caused you to lose time from work?

No ☐

Yes ☐

Please provide details including dates

10 Are you limited in your ability to work or to perform your activities of daily living as a result of this condition?

No ☐

Yes ☐

Please provide details

11 Do you continue to experience symptoms?

No ☐ ***Go to question 12***

Yes ☐ ***Go to question 13***

12 When did you last experience symptoms?

13 Describe your symptoms

DECLARATION

The answers to the questions above are true and complete and this supplementary questionnaire forms part of my application for insurance.

Signature

X ..... Date / /

Please return this completed form to:

Smartsave
PO Box 1282
Albury
NSW 2640