

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 (including but not limited to: adjustment disorder, anxiety, depression, bipolar disorder, post-traumatic stress disorder, schizophrenia, eating disorder, attention deficit disorder, Asperger disorder, Autism disorder)? Yes No
- If yes, please indicate the medical diagnosis and proceed with the following questions. If more than one diagnosis, list them all below:
 - If no, please sign and date at the bottom of the questionnaire.
- 1) Medical diagnosis and date of diagnosis: _____
- 2) Medical diagnosis and date of diagnosis: _____
- 3) Medical diagnosis and date of diagnosis: _____
- Was any cause identified? If yes, please give details: _____ Yes No

2. Please indicate which of the following apply to your condition(s) and provide the relevant information in the columns to the right for each symptom/episode or treatment :

| | Date first symptoms/episodes or treatment | Frequency of symptoms/episodes or treatment | Date last symptoms/episodes or treatment |
|-----------------------------------------------------|-------------------------------------------|---------------------------------------------|------------------------------------------|
| <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"/> Trouble concentrating | | | |
| <input type="checkbox"/> Eating disorder | | | |
| <input type="checkbox"/> Counselling | | | |
| <input type="checkbox"/> Psychologist | | | |
| <input type="checkbox"/> Psychiatrist | | | |
| <input type="checkbox"/> Other symptoms (specify) : | | | |

3. Are you currently taking any medication for any of the above-mentioned conditions? If yes, please list the name of any medication. Yes No
- _____
4. Have you ever taken any medication for any of the above-mentioned conditions in the past, other than those listed in question 3? Yes No
- If yes, please list the name of the medication(s) and date(s) taken: _____
- _____
5. Was any hospitalization required for any of these conditions? Yes No
- If yes, dates and duration: _____
6. a) For an adult or student, was any time off work or school required for any of the above-mentioned conditions? N/A Yes No
- If yes, dates and duration: _____
- b) For a child or a student, are you experiencing any antisocial behaviors? N/A Yes No
- If yes, explain: _____
- c) For a student, are you attending an adapted school program? N/A Yes No
- If yes, explain: _____
7. a) Do you use any unprescribed drugs or prescribed marijuana products? Yes No
- b) Do you consume alcohol? Yes No
- If yes, please provide details (date and type (drug or alcohol), quantity and frequency per day, week, month or yearly). For prescribed marijuana, specify the reason for prescription : _____
8. Do you have any pending consultation or treatment for any of the above-mentioned conditions? Yes No
- If yes, please provide details (date, treatment, name of attending physician). _____
9. 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)