Desjardins
Financial Security

Group Network

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ANXIETY or EMOTIONAL/STRESS DISORDER QUESTIONNAIRE

NAME: _____ DATE OF BIRTH: _____

POLICY NO.: _____ GASC NO.: _____

1. Dates of first indications of: fatigue _____ depression _____ suicidal thoughts _____
   insomnia _____ weight loss _____ nervousness _____
   and what you thought cause was: _____
2. Name and address of doctor currently treating above noted condition _____
   _____
3. Date you first consulted for above and what was doctor's diagnosis? _____
   _____
4. Details of any treatments, medications prescribed by doctor _____
   _____
5. Are symptoms: abated _____ similar _____ more severe ___
6. Are you still under treatment and/or medication? If yes, please provide details including average monthly cost.
   _____
7. Date of last visit to current doctor consulting for condition and frequency of visits (i.e. weekly, monthly) _____
   _____
8. Have you been or recommended to be hospitalized or have any tests? Yes _____ No _____
   If yes, please give names and address of hospitals, name and dates of tests and details of recommendations
   _____
9. Have you ever had time off work due to above problems? Yes _____ No _____
   If yes, please advise dates of disability: From _____ to _____
   From _____ to _____
10. What is your average alcohol, wine, beer consumption per week? _____
    _____
11. Have you ever used drugs other than as prescribed by a physician? Yes _____ No _____
    If yes, please provide names of drugs used, frequency and amounts _____
    _____
12. Have you completely recovered from your condition? Yes _____ No _____
    If no, please explain: _____
    _____

_____ _____

DATE SIGNATURE

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