Additional Medical Questionnaire

Name: _____ Date of Birth: _____

Medical/ Health Condition Concerned: _____

(Please tick the appropriate brackets when answering the below questions)

1. Description of signs and symptoms
   (a) What signs and symptoms did you experience _____

      i. Was there a specific trigger or precipitating event? _____

   (b) When did the signs and symptoms first occur? _____. When was the condition diagnosed? _____

   (c) Have you experienced symptoms in the last 12 months?

      (◯) No (◯) Yes – how frequently do they occur? _____

   (d) Have you ever experienced any of the following symptoms? If yes, tell us when they occurred and/or how long they lasted
      (☐) Signs and symptoms of depression _____
      (☐) Hallucinations (i.e. visual, auditory, touch) _____
      (☐) Social withdrawal/ isolation _____
      (☐) Changes in sensation or movement _____
      (☐) Physical harm to yourself or others _____
      (☐) Suicidal thoughts or attempts _____
      (☐) Other – please specify _____

2. Diagnostic procedure:

   (a) Has your condition been diagnosed by a physician, psychiatrist, or clinical psychologist?

      (◯) No (◯) Yes – please provide details _____

      i. Please provide the contact details of this clinician _____

   (b) What was the final diagnosis? _____

   (c) Have you been diagnosed with any other psychological disorders?

      (◯) No (◯) Yes – please provide the diagnosis and when this occurred _____

3. Co-morbidities:

   (a) Has the condition affected your ability to work?

      (◯) No (◯) Yes – please provide details _____

   (b) Have you ever suffered from any alcohol or substance abuse?

      (◯) No (◯) Yes – please provide details of the substance, when this occurred, and the duration

      _____

   (c) Have you suffered from any physical disorders? E.g. weight changes, heart palpitations, bowel problems etc.

      (◯) No (◯) Yes – please provide details _____

4. Treatment (Please tick the appropriate brackets and specify period of treatment with commencement and completion date)
   (☐) Psychological therapy _____
   (☐) Counseling/ group support _____
   (☐) Medication _____
   (☐) Hospitalization/ rehabilitation _____
   (☐) Chinese medicine or others _____

   Did your symptoms respond to treatment? (○) Yes, completely (○) No, please provide details of symptoms:

   _____

5. Are you currently receiving any treatment such as medication, physiotherapy or Chinese medicine treatment etc.?

   (○) No (○) Yes – please provide details of treatment _____

6. Is regular follow-up required? (○) No (○) Yes

   Date of latest follow up _____ Date of next follow up _____

Please provide updated clinician report from the attending physician giving details of the diagnosis, results of assessment, details of treatment & counseling, response to treatment, complications and prognosis.

I hereby declare that all answers to the foregoing questions are correctly recorded, and that they are full, complete, and true.

Signature of the proposed insured Date