Manulife China Bank
LIFE ASSURANCE CORPORATION
a joint venture between Manulife Philippines and China Banking Corporation

Anxiety / Depression / Nervous Disorder / Mental Illness Questionnaire

For Completion by the Attending Physician.

Name of Applicant: _____ **Date of Birth:** _____

1. What was the diagnosis of the condition?

2. Please advise:

i. Date symptoms first commenced

ii. Date patient first presented with symptoms
(please advise if you are aware of any prior consultations with other practitioners)

iii. Does the patient still suffer from symptoms? ☐ **Yes** ☐ **No**
Please give date last symptoms experienced

3. What were the presenting symptoms?

4. Did the condition develop as a reaction to particular circumstances? ☐ **Yes** ☐ **No**
If "yes" please describe circumstances

5. Have there been any suicidal ideation or actual suicide attempts? ☐ **Yes** ☐ **No**
If "yes" please give full details including dates.

6. Were there any symptoms of a psychosomatic nature ☐ **Yes** ☐ **No**
eg. palpitations, chest pain, IBS, dyspepsia, migraine, etc? If "yes" please provide details including dates, results of investigations and treatment .

7. Please advise:

Has medication ever been prescribed? ☐ **Yes** ☐ **No**
If "yes" advise type and dosage.

Is the patient still taking medication? ☐ **Yes** ☐ **No**
If "yes" advise type and dosage

Is the patient receiving any other ongoing therapy in relation to this condition?
If "yes please advise. ☐ **Yes** ☐ **No**

Has electroconvulsive therapy ever been necessary? ☐ **Yes** ☐ **No**
If "yes" advise dates and number of treatments.

Has the patient ever required hospitalisation? ☐ **Yes** ☐ **No**
If "yes" advise dates, duration and name of hospital.

8. Has your patient ever been referred to a psychiatrist, psychologist, counsellor or any other therapist?
If "yes" please advise dates, names and addresses (a copy of any specialist reports in your possession would be appreciated) ☐ **Yes** ☐ **No**

9. Has the patient ever been off work or has normal daily activities been restricted in any way due to-this condition? ☐ **Yes** ☐ **No**
If "yes" please advise details including when and for how long.

Is the patient now able to perform his/her usual occupation and normal daily activities without restriction? If "no" please give details. ☐ **Yes** ☐ **No**

_____ _____

Signature of Attending Physician **Date**