

Questionnaire Mental health, behavioral and/or developmental disorders

Please complete block 1 and or 2 depending on your situation and block 3 at all times

First and last names of insured					
Date of birth Policy/a	pplication number				
Mental health or behavioral dis	ordoro Ploak 1				
mental health or behavioral dis	Gorders - Block 1				
What is the nature of the mental h Places should the appropriate haves.	ealth or behavioral disorders?				
Please check the appropriate boxes: Depression	☐ Anxiety/Panic disorder	□ Incompio			
☐ Adjustment disorder	☐ Burn-out (related to work/school)	☐ Insomnia☐ Obsessive-compulsive disorder			
☐ Personality disorder	☐ Post traumatic stress disorder	☐ Bipolar dis			
☐ Psychosis	☐ Schizophrenia		sorder		
☐ Attention deficit disorder (ADD/ADHD)		rnhagia)			
	Attention deficit disorder (ADD/ADHD)				
2. For each condition diagnosed, ple	For each condition diagnosed, please complete the table below for each epiosde.				
Condition		Start date	End date		
		Y Y Y Y M M	Y Y Y Y M M		
		[Y , Y , Y , Y] M , M	Y Y Y Y M M		
		Y Y Y Y M M	[Y , Y , Y , Y] M , M		
		Y Y Y Y M M	Y Y Y Y M M		
		YYYYMM	YYYYMM		
3 Have you consulted dectors or there	apists for any of the conditions mentionn	od abovo2 □ Vos □	No		
If yes, complete the information below:	apists for any of the conditions mentioning		NO		
Condition:					
Profession:					
Name:					
Address:					
Date of first consultation:					
Date of last consultation and result:					
Date of the next consultation:					
Frequency of the consultations:					
Condition:					
Profession:					
Name:					
Address:					
Date of first consultation:					
Date of last consultation and result:					
Date of the next consultation:					
Frequency of the consultations:					

	Condition:				
	Profession:				
	Name:				
	Address:				
	Date of first consultation:				
	Date of last consultation and result:				
	Date of the next consultation:				
	Frequency of the consultations:				
4.	Are you taking or have you taken medic	ation(s) for any of the conditions	s mentioned above? □ Ye	es □ No	
	If yes, please complete the table below:	(-, ,	_	-	
	Condition	Medication/Dosage	Start date	End date	
			I V V V V I M M I	IV V V VIM MI	
			[Y,Y,Y,Y]M,M]	YYYYM	
			[Y , Y , Y , M , M]	YYYYMM	
			Y Y Y Y M M	$\begin{array}{c ccccccccccccccccccccccccccccccccccc$	
			Y Y Y Y M M	Y Y Y Y M M	
_					
5.	Has your medication changed in the la If yes please specify the changes:	IST 12 MONTHS? U YES U NO			
	in yes please specify the changes.				
_			0 F.V. F.N.		
6.	Have you been hospitalized for one of the conditions mentionned above? ☐ Yes ☐ No If yes, complete the table below:				
		Dearen	Start date	Food data	
	Hospital's name	Reason		End date	
			[Y , Y , Y , Y M , M	[Y , Y , Y , Y , M , M]	
			[Y , Y , Y , Y , M , M]	Y Y Y Y M M	
			[Y , Y , Y , Y M , M]	Y Y Y Y M M	
_	Harris and the description of the second of		N-		
7.	Have you ever had suicidal thoughts a If yes, please complete the table below:	nd/or suicide attempts? U Ye	es u no		
	if yes, please complete the table below.	Datas ar parioda			
		Dates or periods			
	Suicidal thoughts				
	Suicide attempts				
8.	Have you had to take time off work/sc	hool or were there any limitation	ons in your work schedule	or in your daily	
	occupations? ☐ Yes ☐ No				
	If yes, complete the table below:				
	Condition	Absences or limitations	Start date	End date	
			Y Y Y Y M M	Y Y Y Y M M	
			[Y,Y,Y,Y]M,M]	Y Y Y Y M M M	

3. Have you consulted doctors or therapists for any of the conditions mentionned above? (continued)

S	specify:	
С	Condition	Current state
		☐ Completely recovered, date of last symptoms: ☐ Y , Y , Y , Y , M , M ☐ Sequelae, specify:
		☐ Completely recovered, date of last symptoms: ☐ Y , Y , Y , Y , M , M ☐ Sequelae, specify:
		☐ Completely recovered, date of last symptoms: ☐ Y , Y , Y , Y , M , M ☐ Sequelae, specify:
		☐ Completely recovered, date of last symptoms: ☐ Y , Y , Y , Y , M , M ☐ Sequelae, specify:
10. <i>A</i>	Additional information	
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	velopmental disorders – Block 2	
1. V	What is the nature of the developmental d	lisorders?
1. V	Please check the appropriate boxes: Intellectual impairment Down Syndrom	lisorders?
1. V	Please check the appropriate boxes:	
1. V	Please check the appropriate boxes: Intellectual impairment Down Syndrom Any other developmental disorder: specify: Date of diagnosis: Y, Y, Y, Y, M, M	
1. V P C 2. C 3. H	Please check the appropriate boxes: Intellectual impairment Down Syndrom Any other developmental disorder: specify: Date of diagnosis: Y,Y,Y,Y,M,M Have you consulted doctors or therapists for yes, complete the information below:	☐ Autism spectrum disorder
1. V	Please check the appropriate boxes: Intellectual impairment Down Syndrom Any other developmental disorder: specify: Date of diagnosis: Y,Y,Y,Y,M,M Have you consulted doctors or therapists for syes, complete the information below: Condition:	☐ Autism spectrum disorder
1. V	Please check the appropriate boxes: Intellectual impairment Down Syndrom Any other developmental disorder: specify: Date of diagnosis: Y,Y,Y,Y,M,M Have you consulted doctors or therapists for eyes, complete the information below: Condition:	☐ Autism spectrum disorder
1. V P C C C C C C C C C C C C C C C C C C	Please check the appropriate boxes: Intellectual impairment Down Syndrom Any other developmental disorder: specify: Date of diagnosis: Y,Y,Y,Y,M,M Plave you consulted doctors or therapists for yes, complete the information below: Condition: Profession:	☐ Autism spectrum disorder
1. V	Please check the appropriate boxes: Intellectual impairment Down Syndrom Any other developmental disorder: specify: Date of diagnosis: Y,Y,Y,Y,M,M Have you consulted doctors or therapists for yes, complete the information below: Condition: Profession: Idame:	☐ Autism spectrum disorder
1. V P P C C C C C C C C C C C C C C C C C	Please check the appropriate boxes: Intellectual impairment Down Syndrom Any other developmental disorder: specify: Date of diagnosis: Y,Y,Y,Y,M,M Alave you consulted doctors or therapists for yes, complete the information below: Condition: Profession: Itame: Address: Date of first consultation:	☐ Autism spectrum disorder
11. V	Please check the appropriate boxes: Intellectual impairment Down Syndrom Any other developmental disorder: specify: Date of diagnosis: Y,Y,Y,Y,M,M Have you consulted doctors or therapists for yes, complete the information below: Condition: Profession: Date of first consultation: Date of last consultation and result:	☐ Autism spectrum disorder
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9. What is your current state?

4.	Are you taking or have you taken medication(s) for any of the conditions mentioned above? Yes No					
	If yes, please complete the table below: Condition	Medication/Dosage	Start date	End date		
			Y Y Y Y M M	Y Y Y Y M M		
			Y Y Y Y M M	Y Y Y Y M M		
5.	Compared to someone the same age as you, are you able to perform the activities of daily life and the activities of domestic life without assistance? Yes No					
	If no, specify:					
6.	Do you need special accomodation or support to do a gainful work or to attend a school? Yes No If yes, specify:					
7.	Additional information					
D	eclaration and signature (must b	e filled at all times) – Block 3				
1.	Declaration					
	I acknowledge having fully understood all of the questions above and that the answers given are true and complete. In addition, I consent to having them as an integral part of the requested insurance policy.					
	x		[Y,Y,Y,Y]M,I	M D D		
	Signature of insured (signature of the father, mother	er or legal guardian if the insured is a minor)	Date of signature			