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Anxiety / Depression Questionnaire

Claims Administrator:
Consociate•Dansig
Attn: Underwriting
111 E. Decatur Street, P.O. Box 1068
Decatur, IL 62525
Phone: (888) 242-4357
Fax: (217) 451-9088

Group name:____

Employee name:____

Dependent name (if condition is for dependent) _________________________

Age: __________ Height: __________ Weight: __________

1. Circle the medical condition that has been diagnosed. Anxiety or Depression

   When did the symptoms first begin? ______________________________

   Cause; if known: _______________________________________

2. What problems or symptoms have been experienced with this condition, and the last time they occurred? ______________________________________

   ____

3. Do you attend therapy and/or counseling? Yes or No

   How often? ___________/week or ___________/month

   Date of last visit: ____________________ Recommendation: ___________________

   ____

4. Any hospitalizations resulting from condition? Yes or No

   In-patient length of stay: _______________________________________

   Out-patient length of stay:_______________________________________

5. List all past and current medications taken (for this and any other condition)

Medication	Dosage	Frequency	Last Taken Date

6. Any loss of time from work/school due to this condition? Yes or No

   When?____

   How many days/weeks/months were missed? _________________________

7. Has suicide been threatened or attempted? Yes or No If yes, when? ________

8. Any history of alcohol or drug abuse? Yes or No If yes, complete the appropriate questionnaire(s).

Please be advised that you may be required to submit medical records.

Employee signature: ______________________________________ Date: ____________