

# Psychiatric 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. Name of specific diagnosis \_\_\_\_\_

2. What symptoms were experienced, and when did they begin? \_\_\_\_\_

\_\_\_\_\_ Any current symptoms? Yes or No

If yes, describe: \_\_\_\_\_

3. Date therapy began? \_\_\_\_\_ Frequency of visits? \_\_\_\_\_

4. Date last seen for therapy/counseling? \_\_\_\_\_

5. Any hospitalization? Yes or No If so, when? \_\_\_\_\_

Inpatient length of stay? \_\_\_\_\_

Outpatient length of stay? \_\_\_\_\_

6. Any lost time from work due to psychiatric illness? Yes or No If yes, when and how long? \_\_\_\_\_ Returned to work full time? Yes or No

7. Has suicide ever been attempted or threatened? If yes, when? \_\_\_\_\_

8. List all medications, including dosage frequency and last date taken: \_\_\_\_\_

\_\_\_\_\_

9. Any history of alcohol or drug abuse? If yes, complete the appropriate questionnaire.

List any other condition(s) you are being treated for: \_\_\_\_\_

\_\_\_\_\_

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

Employee signature: \_\_\_\_\_ Date: \_\_\_\_\_

