ANXIETY/DEPRESSION

Please fax back to IPA at 781 643-2775

Name: ____DOB: ___________________

1. Date of first indication of: fatigue_________ depression _________ suicidal thoughts ___________ insomnia _________ weight loss ________ nervousness _ ____________ or what do you think caused any problems ___________________
2. Name and address of physician who initially treated you: ____________________
   ____
   ____
3. Date of first consultation: ____
4. Details of treatment and medication: _____________________________________
5. Have you ever been hospitalized? ____
6. Are you still under treatment? ____
7. Name of physician currently treating you? _________________________________
   ____
   ____
8. Have you ever had to take time off of work due to your illness? _______________
9. If so, when? ____
10. What is your average alcohol consumption on a weekly basis? _______________
11. Have you ever used any drugs other than prescribed by your physician? ________
    ____

Agent Name: ____

Phone Number:_________________________Fax No:____________________________

Date: ____________________ E-mail Address: ______________________________

Please circle the associate you work with. Russ, Rhonda, Leo