

7. Have you ever been hospitalized for this condition?

YES NO

If "YES" please provide more information:

a) Date (s) and duration of each hospitalization _____

b) Reason for hospitalization _____

8. Have you ever had electro-convulsive therapy for this condition?

YES NO

If "YES", please supply date (s): _____

9. Have you ever had any psychotherapy or counseling for this condition?

YES NO

If "YES", please provide more information:

a) Date of onset: _____

b) Interval of sessions: _____

c) Are you still receiving psychotherapy or counseling?

YES NO

If "NO", when was your last session? _____

10. Please state any precipitating factors for your condition _____

11. Have you ever contemplated or attempted taking your own life?

YES NO

If "YES", please supply date (s): _____

12. Please supply contact details for all doctors and/or alternative medical practitioners who treated your condition.

Doctor's Name

Address

Telephone Number

I hereby declare that the above particulars and answers are complete and true.

Signed at _____ this _____ day of _____

Signature of Applicant