Behavioral Health Questionnaire

Life Insurance Company of North America
Connecticut General Life Insurance Company
Cigna Life Insurance Company of New York

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Claimant Name:	Date of Birth:
List Dates of Treatment (including first and most recent):	Next Scheduled Office Visit:

DSM-IV DIAGNOSIS AND DESCRIPTION

DSM-IV TR:

Axis I: _____

Axis II: _____

Axis III: _____

Axis IV: _____

Axis V (GAF): Current: _____ Past Year: _____ Baseline: _____

Please provide Clinical Signs and Symptoms impacting functionality, intensity and duration which meet your above diagnosis (i.e. - cognitive impairment, functional impairment and suicidal/homicidal history and risk):

OR

DSM-5 DIAGNOSIS CODE AND DESCRIPTION

DSM-5:

Please list all diagnosis:

Please provide Clinical Signs and Symptoms impacting functionality, intensity and duration which meet your above diagnosis (i.e. - cognitive impairment, functional impairment and suicidal/homicidal history and risk):

MENTAL STATUS EXAM

Date of Exam:	Alertness:	Orientation:

Behavior/Psychomotor Speed:	Speech:	Mood:	Affect:

Thought Process:	Thought Content:

Judgment *(please provide actual examples if judgment is poor):*

Insight:

Cognitive Impairment *(please provide how assessed)*:

SUBSTANCE ABUSE HISTORY

Does your patient have a substance abuse history?

☐ Yes ☐ No *If yes, describe further:*

Is your patient currently abusing chemicals?

☐ Yes ☐ No

PAST PSYCHIATRIC HISTORY

Has there been past treatment for this psychiatric diagnosis or any other psychiatric diagnosis? ☐ Yes ☐ No *If yes, describe further:*

Diagnosis: _____

Treatment Received: _____

Hospitalized: _____

YOUR PATIENT'S SOCIAL INTERACTIONS/DEMEANOR

Please state current frequency and types of interactions with friends and family:

PERFORMANCE OF ACTIVITIES OF DAILY LIVING

Please describe your patient's current activities of daily living *(e.g. personal care, bathing, grooming, cooking, driving, managing check book, transportation):*

What specific activities or tasks is your patient unable to perform to impact their ability to work?

TREATMENT/TREATMENT PLAN

Please list current medications, dosages and blood levels, if applicable.

Medication	Dosage	Start Date	Last Change

Please indicate your treatment goals and target date for achievement of the treatment goals.

RETURN TO WORK PLAN

A. What is the date your patient may return to work?

B. Is your patient able to return to work full time? ☐ Yes ☐ No

C. If your patient can not return to work full time, can your patient return to work on a part time or gradual basis? ☐ Yes ☐ No

If not, please describe any restrictions and limitations you are placing on your patient and provide the clinical observations and test results to support these findings.

REFERRALS

Have you made referrals to other treating provider(s) *(e.g., psychiatrist, counselor)?* ☐ Yes ☐ No
If yes, please provide the name(s) and the phone number(s) of the provider(s):

If you have not made such referrals, please provide the rationale:

ALTERNATIVE WORK SETTING

Can your patient currently perform his or her job duties in an alternative work setting? ☐ Yes ☐ No
Please Explain:

ABILITY TO PERFORM

Please indicate your patient's ability to perform the following Temperaments:	Yes	No	N/A
Directing, Controlling, Planning: *Able to accept responsibility for control, direction, or planning of an activity.*	☐	☐	☐
Performing Repetitive Work: *Able to perform repetitive or continuous activity according to set procedures.*	☐	☐	☐
Influencing People: *Able to influence people in their opinions, attitudes, or judgments about ideas or things.*	☐	☐	☐
Performing a Variety of Duties: *Able to perform a variety of duties, often from one task to another without loss of efficiency or composure.*	☐	☐	☐
Expressing Personal Feelings: *Able to interpret feelings, ideas or facts in terms of personal viewpoint.*	☐	☐	☐
Working Alone or in Isolation: *Able to be without face-to-face contact for extended periods of time.*	☐	☐	☐
Performing Under Stress: *Able to perform under stress when confronted with emergencies or unusual situations.*	☐	☐	☐
Attaining Precise Limits/Tolerances: *Able to perform with demands of precise attainment of set limits, tolerances, or standards.*	☐	☐	☐
Following Specific Instructions: *Able to perform without room for independent action or judgment.*	☐	☐	☐
Dealing with People*: Able to deal with people beyond giving and receiving instruction such as working as a member of a team or committee.*	☐	☐	☐
Making Judgments and Decisions: *Able to make generalizations, judgments, or decisions based on subjective or objective criteria such as with the five senses or with factual data.*	☐	☐	☐

Please summarize your patient's functional psychological and cognitive strengths, abilities and limitations as it relates to concentration, memory, and/or attention. If there are no limitations in concentration, memory, and/or attention, how does this impact your patent's ability to work? Please document the clinical observations and test results to support these findings.

PROVIDER INFORMATION

Provider Name *(please print):*		Telephone #:
Address:		
Fax #:	Credentials (MD, DO, PhD, Other):	Specialty:
Provider Signature:		Date: