

Group Risk

Personal Statement

July 2008



> INVESTMENT > INSURANCE
> SUPERANNUATION

Important notice

ING Life Limited (ING Life) is the insurer in respect of a group insurance arrangement. It is important that you have read and understood the current Product Disclosure Statement for the cover for which you are applying.

You are requested to complete this form if one of the following applies to you:

- you are proposing to become an insured member under the policy and your benefits are subject to assessment by ING Life
- you are an existing insured member and your benefit (or part thereof) is subject to assessment by ING Life.

ING Life requires this Personal Statement and other health information to assist us in making a decision on your proposed insurance cover. This Personal Statement is confidential. Please refer to the Privacy Statement in the Product Disclosure Statement.

You may wish to seal it in an envelope and send it to:

ING Life Limited
GPO Box 4129
Sydney NSW 2001

Your duty of disclosure

You have a duty under the Insurance Contracts Act 1984 (Cth) to disclose to the insurer every matter that you know or could reasonably be expected to know, is relevant to the insurer's decision whether to accept the risk of insurance and, if so, on what terms.

Your duty of disclosure applies even after your application is completed and until the insurer has assessed and accepted your application for insurance cover, or an increase in cover.

You have the same duty to disclose those matters to the insurer before you change your insurance cover or apply for new cover. Your duty, however, does not require disclosure of a matter that:

- diminishes the risk to be undertaken by the insurer
- is of common knowledge
- the insurer knows, or in the ordinary course of business, ought to know or
- the insurer has waived.

Non-disclosure

If you fail to comply with your duty of disclosure and the insurer would not have entered into the contract on any terms if the failure had not occurred, the insurer may avoid the contract within three years of entering into it. If your non-disclosure is fraudulent, the insurer may avoid the contract at any time.

An insurer who is entitled to avoid a contract of life insurance may, within three years of entering into it, elect not to avoid it but to reduce the sum that you have been insured for in accordance with a formula that takes into account the premium that would have been payable if you had disclosed all relevant matters to the insurer.

ING Life Limited
ABN 33 009 657 176
AFSL 238341

GPO Box 4129
Sydney NSW 2001

347 Kent Street
Sydney NSW 2000

Tel 133 667
Fax 02 9234 8970

Type of Fund/Plan

Please tick the appropriate box Group Life Group Salary Continuance

Policy number (if known)

Name of Fund/Plan

Type of cover

- Death Only
- Death and Total and Permanent Disablement (TPD)
- Group Salary Continuance (monthly benefit)

Amount of benefit/cover

\$, .

\$, .

\$, .

1. Personal details

Dr/Mr/Mrs/Miss/Ms (please circle one)	Surname	First name
Gender	<input type="checkbox"/> Male <input type="checkbox"/> Female	Date of birth / /
Phone (h)	(w)	(m)
Email		

May one of our underwriting staff or ING authorised service providers contact you by phone if we require more information? Yes No
 If **yes**, when is the most convenient day(s) and time and on which phone number?

Days	Time: From To	Phone (h) <input type="checkbox"/> (w) <input type="checkbox"/> (m) <input type="checkbox"/>
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2. Residence and travel details

1. Are you a permanent resident of Australia? Yes No

2. How long have you lived in Australia? years months

3. Do you have any intention of travelling outside Australia within the next two years? Yes No

If **yes**, please complete the following:

Date of departure / /	Duration of stay	Destination(s) (country/cities)
-----------------------	------------------	---------------------------------

Purpose of stay: Holiday Business Residing Other Please specify if other

3. Insurance details

1. Do you have, or have you previously applied for any life, TPD, trauma, income protection, business expense or living expense cover with ING Life or any other company? (Note, this includes insurance through your superannuation fund and insurance your employer may have arranged for you.) Yes No

2. Do you intend to replace all or part of an existing insurance or insurance cancelled within the past two months? Yes No

If **yes** to question 1 or 2, please indicate which insurance(s) and provide details of the date the policy was last fully underwritten in the table below:

Name of company	Type of cover	Amount insured	Date commenced	Will this policy be discontinued/replaced?	Date last fully underwritten (replacement policies only)
		\$	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
		\$	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
		\$	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /
		\$	/ /	<input type="checkbox"/> Yes <input type="checkbox"/> No	/ /

3. Have you ever had an application for insurance on your life declined, deferred, accepted with a higher than normal premium or issued with restrictions or exclusions? Yes No

If **yes**, please provide name of company, alteration, date and reason (if known).

4. Have you ever made a claim for or received sickness, accident or disability benefits, Veterans Affairs benefits, Workers' Compensation, unemployment benefits or any other form of compensation? Yes No

If **yes**, please provide details i.e. when, amount, period paid, type of disability suffered, date claim finalised etc.

4. Occupation details

Occupation

Describe all present duties in the table below (please complete both percentage of time and specific duties in all cases)

Type of work	% of time	Please describe your specific duties and where they are performed. Please note the examples below are to be used as a guide only.
Sedentary/administration		(e.g. filing, computer work, answering telephone, reception duties, etc.)
Manual work – light		(e.g. driving, warehousing, surveying, lifting under 5kgs, etc.)
Manual work – heavy		(e.g. bricklaying, lifting over 5kgs, painting, carpentry, mechanic, etc.)

How many hours do you work per week?

Annual salary (before tax)

5. Pastimes

Have you any intention of engaging in:

1. motorcycle/motor racing other than as a means of transportation to and from work? Yes No
2. any hazardous activities or sports, e.g. motor or water sports (such as canoeing), football, parachuting, recreations involving heights, underwater sports, caving, body contact sports, gliding, hang gliding etc? Yes No
3. aviation/flying, other than as a fare-paying passenger? Yes No

If you answered **yes** to any of questions 1, 2 or 3 above, please continue completing this section below for the relevant activity.

Motorcycle/motor racing

Vehicle type	Races p.a.
Engine size	Max. speed (km/h)
Class	<input type="checkbox"/> Recreational <input type="checkbox"/> Amateur <input type="checkbox"/> Professional

Scuba/skin diving

Average depth (m)	Maximum depth (m)
Dives p.a.	Do you use explosives?

Do you dive in caves or potholes? Yes No If **yes**, give details

Football/Soccer/Aussie Rules, etc.

Code played and grade

Games p.a.

Recreational Amateur Professional

Do you receive any income participating in Football/Soccer/Aussie Rules etc.?

If **yes**, provide amount and details

Other sports or pastimes

a. Please provide details and frequency of any other hazardous activities or sports you participate in (e.g. boxing, competitive riding, mountain climbing, body contact sports, caving, etc.).

If **yes**, provide frequency and details

b. On what basis do you partake in this activity? Recreational Amateur Professional

Aviation/flying

Do you hold a Civil Aviation Safety Authority (CASA) licence? Yes No

If **yes**, state type and period held

Do you intend to change the scope of your present licence? Yes No

Have you ever had an accident or been charged with violating CASA regulations? Yes No

Do you always use authorised landing areas? Yes No

Please complete the table below.

No. of hours flown	Past 12 months		Future annual average	
	Crew	Passenger	Crew	Passenger
Commercial airline				
Charter				
Private				
Aero club/flying school				
Agriculture				
Helicopter				
Ultralight aircraft				

Do you intend to engage in any form of aviation other than the above categories (e.g. ballooning, aerobatics, parachuting, paragliding, etc.)?

Yes No

If **yes**, please provide frequency and details.

6. Personal health statement

1. What is your current height and weight?

Height (cm)

Weight (kg)

2. Has your weight varied by more than 10 kg during the last 12 months? Yes No

If yes, please provide details

3. During the last 12 months have you smoked tobacco or any other substance? Yes No

If yes, please state **type** and **quantity** per day

4. During the last three months, have you used nicotine replacement treatment? Yes No

If yes, please state **type** used and **duration** of use

5. Non-smokers – Have you ever smoked regularly in the past? Yes No

If yes, please state **type**, **quantity** per day and date ceased

6. Do you consume alcohol? Yes No

If yes, please state **type** and **quantity** per day (the word 'social' is not sufficient)

7. Have you ever been advised to stop smoking or drinking alcohol on medical grounds? Yes No

If yes, please provide full details

8. Has the virus which causes AIDS (the Human Immunodeficiency Virus) ever infected you or are you carrying antibodies to that virus? Yes No

9. Have you **ever** engaged in sexual activity with, or worked as, a prostitute; or engaged in anal sexual activity? Yes No

If **yes**, a confidential questionnaire will be sent to you to complete and return to ING's underwriting department.

If you are required to a have a full medical examination, go to section 9.

7. Family history

To be completed for your blood relatives only (if adopted and family history unknown, please state so).

1. Have any of your parents, brothers or sisters (alive or deceased) suffered from Huntington's disease, muscular dystrophy, cystic fibrosis, familial polyposis, polycystic disease, Alzheimer's disease, dementia or any other hereditary or familial disorder? Yes No

2. Have any of your parents, brothers or sisters (alive or deceased) been diagnosed with any of the following conditions: diabetes, heart disease, mental illness, haemophilia, haemochromatosis, high blood pressure, high cholesterol, breast cancer, bowel cancer or any other cancer (please specify type), stroke or kidney disease? Yes No

If you answered **yes** to either question 1 or 2, please complete the following:

Relation	Condition/disorder	Age diagnosed

8. Medical history

To the best of your knowledge, have you ever had any of the following:

Please tick the appropriate box and circle the specific conditions that are applicable.

1. **Asthma?** Yes No
2. **High blood pressure?** Yes No
3. **High cholesterol?** Yes No
4. **Diabetes?** Yes No
5. **Stress, anxiety, depression or any other mental health condition?** Yes No
6. **Back or neck pain, sciatica or any disorder of the spine or neck?** Yes No
7. **Arthritis, shoulder or knee pain or any other disorder of the joints?** Yes No
8. **Cyst, mole or skin lesion?** Yes No

If you answered **yes** to any of the conditions in bold above, please complete the relevant questionnaire on pages 10 to 17.

9. Sleep apnoea, bronchitis, persistent cough or any other chest or lung condition? Yes No
10. Heart condition, murmur, chest pain, rheumatic fever, palpitations, stroke or vascular disorder? Yes No
11. Thyroid or glandular trouble? Yes No
12. Ulcers, bowel trouble or recurring indigestion? Yes No
13. Epilepsy, fits or dizziness of any kind or persistent headaches? Yes No
14. Alzheimer's disease or dementia? Yes No
15. Kidney, liver or bladder problems, renal colic or stones, nephritis, lupus nephritis, pyelitis or cystitis? Yes No
16. Broken bones or osteoporosis or any pain, strain or disorder of any muscles, ligaments, cartilage or limbs? Yes No
17. Gout, fibromyalgia, tendonitis, tenosynovitis, RSI, or any regional pain syndrome, chronic fatigue syndrome (myalgic encephalomyelitis)? Yes No
18. Cancer, tumour, growths of any kind or breast lumps (even if you have not seen a doctor)? Yes No
19. Varicose veins, hernia or skin trouble? Yes No
20. Any abnormality affecting eyesight, hearing or speech? Yes No
21. Any abnormality affecting physical mobility or muscular power (e.g. multiple sclerosis)? Yes No
22. Anaemia, haemophilia or any other disease of the blood? Yes No
23. Bowel, liver or gall bladder disease or hepatitis? Yes No
24. Coughing of blood or passing of blood from the bowel or in the urine? Yes No
25. Any sexually transmittable disease including but not limited to AIDS or its positive antibodies, gonorrhoea or syphilis? Yes No
26. Have you within the last five years had any other illness, injury, operation, X-ray, electrocardiogram, blood transfusion, any other special tests or been advised to have a blood test for any reason? Yes No
27. Due to injury or illness have you ever been off work for more than seven consecutive days? (if not already mentioned) Yes No
28. Do you now have any symptoms of ill health or disability? Yes No
29. Are you contemplating surgery, intending to consult a doctor, or have you been advised to have an operation in the future? Yes No
30. Do you take, or have you ever taken drugs or any medications on a regular or ongoing basis? Yes No
31. Have you ever used or injected any drugs not prescribed for you by a medical attendant? Yes No
32. Are you suffering from unintentional weight loss, persistent night sweats, persistent fever, diarrhoea or swollen glands? Yes No
- 33. Females only**
- a. Have you ever had any complications with pregnancy or childbirth? Yes No
- b. Are you now pregnant? If **yes**, please advise due date / / Yes No
- c. Have you ever had an abnormal cervical smear test (pap), breast ultrasound or mammogram? Yes No
- d. Have you ever had any symptom(s) of, or sought advice or treatment for any condition of the cervix, ovary, uterus, breast, or endometrium? Yes No

If you answered **yes** to any questions from 9–33, please complete the following table. If there is not enough space here, please provide details on page 18.

Question number	Conditions or symptoms	Tests performed and results	Date started	Date ceased	Treatment and type, date provided and date ceased	Time off work	Have you fully recovered? Yes/No	Name and address of institution or health professional

9. Usual doctor or medical centre details

1. Full name and address of usual doctor/medical centre.

Doctor/medical centre		
Phone ()	Fax ()	
No. and street		
Suburb/town	State	Postcode
How many years have you been attending this doctor/medical centre?	Years	Months

2. Have you had any consultations with your usual doctor or any other doctor (other than for colds or the flu) in the last three years not already mentioned? Yes No

If **yes**, please provide details:

Name, address and phone number of doctor/medical centre	Date last consulted	Reason for check up or consultation	Outcome including degree of recovery, medication, treatment, etc.
	/ /		
	/ /		
	/ /		
	/ /		

10. Declaration by the life insured or applicant

- I have read and understood the questions in this Personal Statement.
- I declare that the answers to the questions in this Personal Statement signed by me and given to ING Life Limited and/or the Medical Examiner are true and correct.
- I authorise the collection, use and disclosure of my personal information for the purposes of administration and maintenance of this policy, as outlined in the Privacy Statement. I understand that ING Life Limited will not be able to process a claim or administer this policy without this consent.
- I accept that where my employer (or former employer) or the Trustee of my superannuation fund has appointed a financial adviser or other intermediary to arrange and/or administer the Group Risk policy on their behalf, my personal information will be provided to the financial adviser/intermediary in order to undertake the management and administration of the policy.
- I declare that I have been clearly informed in writing of the general nature and effect of the duty of disclosure.
- I authorise any medical practitioner, other professional or any person named in this Personal Statement to verify any aspect of it, and disclose any information that they may possess about me to ING Life Limited in relation to this insurance.
- I acknowledge that where I am making an application for insurance cover (or an increase in insurance cover), and where such application is made on a voluntary basis (other than as a direct result of the formula for cover which applies to the group risk policy or policies for which an application for cover is being made on the basis of this Personal Statement), that I have received, read and understood a copy of the Group Risk Product Disclosure Statement(s) (PDS) and Plan Summary for the type(s) of cover for which I am applying.

Signature of life insured/applicant

Date

11. Authorisations

Doctor's authorisation

To be completed and signed by the life insured/applicant.

Please sign authorisation

To Doctor

I hereby authorise you to release details of my personal medical history to ING Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by ING. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of life insured/applicant

Date of birth / /

Signature of life insured/applicant

X

Date

Address of life insured/applicant

State

Postcode

Policy number

Doctor's authorisation

To be completed and signed by the life insured/applicant.

Please sign authorisation

To Doctor

I hereby authorise you to release details of my personal medical history to ING Life Limited ABN 33 009 657 176 AFSL 238341, or any organisation duly appointed by ING. A photocopy (or similar) of this authorisation shall be as valid as the original.

Name of life insured/applicant

Date of birth / /

Signature of life insured/applicant

X

Date

Address of life insured/applicant

State

Postcode

Policy number

12. Privacy Statement

ING is committed to ensuring the confidentiality and security of a member's personal information. The ING Privacy Policy detailing our handling of personal information is available upon request or may be downloaded from www.ing.com.au. Members may request access to information held by us about the member, the policy or scheme of which the member is an insured member, and any other ING products or services which the member may hold by contacting the ING Privacy Officer at the address below. The member may assist us by contacting ING Customer Services if any of their personal information is incorrect, has changed or requires updating.

Where the member's employer or superannuation fund trustee (fund) has established a GSC Policy, it may be necessary for us to:

- collect personal information from the member
- collect some personal information about the member from the employer/fund
- disclose some of the member's personal information to the employer/fund in order to undertake the management and administration of the GSC Policy.

In order to undertake the management and administration of our products and services, it may be necessary for us to disclose the member's personal information to certain third parties. Unless the member consents to such disclosure we will not be able to process the application, administer the insurance, process a claim or provide the relevant ING products or services. The types of organisations to whom we may routinely disclose the member's personal information include:

- doctors, medical services or other organisations providing services in the collection, collation or assessment of personal information (including health information) for the purpose of underwriting or assessing your application or assessing any claims
- reinsurance organisations for the purpose of underwriting your application or assessing claims
- organisations undertaking compliance reviews of our financial advisers or reviews of the accuracy and completeness of our information
- organisations maintaining our information technology systems and providing information technology services
- organisations providing analysis and research
- authorised financial institutions, such as banks, credit unions and building societies, providing account details as a mechanism for providing payments or receipt of payments
- organisations providing mailing services and undertaking the printing of our standard documents and correspondence
- Trustees of the member's superannuation fund (if the insurance is linked to such a fund), or their appointed administration company who administers your insurance on their behalf.

We will disclose the member's personal information to these organisations to enable them to undertake specified management and administration services.

For life risk products (including Group Salary Continuance) we collect health information with the member's consent. A member's health information will only be disclosed to service providers such as doctors, reinsurers and assessors who are directly involved in collecting, collating or assessing such information for the purpose of underwriting or assessing the application or assessing any claim. Where the member's insurance forms part of a superannuation fund, we may also be required to provide copies of the member's health information to the Trustees of the fund (or their appointed administrator who administers the insurance cover on their behalf) for purposes such as verifying a decision made by us in accordance with obligations imposed by law). A member's health information will not be disclosed by ING for any other purpose.

We will also disclose a member's personal information in circumstances where we are required by law to do so.

Please note amendments to the Family Law Act 1975 commenced on 28 December 2002 enabling certain persons to request information about a member's interest in a superannuation fund. The policy owner may, if requested, be required to provide information about the member's interest in a superannuation fund to their spouse or a person who intends to enter into an agreement with the member about splitting their superannuation interests in the event of separation of marriage.

Where the member's employer (or former employer) has appointed a financial adviser or other intermediary to arrange and/or administer the Group Salary Continuance Policy on their behalf, we will provide the member's personal information to the financial adviser/intermediary in order to undertake the management and administration of the policy. Where the member wishes to authorise any other parties to act on the member's behalf, to receive information and/or undertake transactions, the member should notify us in writing. If you have any further questions you would like answered about privacy, please write to us or contact us at:

ING Privacy Officer
347 Kent Street
Sydney NSW 2000
Phone 02 9234 8111
Fax 02 9299 3979
Email privacy@ing.com.au

13. Questionnaires

Asthma questionnaire

Only complete this questionnaire if you answered **yes** to question 1 in section 8.

1. When did you have your first episode of asthma?

Date	/	/
------	---	---

2. When was your most recent episode of asthma?

Date	/	/
------	---	---

3. Approximately how many episodes have occurred in the last 12 months?

--

4. Have you had any time off work due to this condition? Yes No

If **yes**, please provide the dates and duration:

5. Are the symptoms/attacks typically precipitated by anything in particular (e.g. seasonal, exercise induced, a cold or bronchitis)? Yes No

If **yes**, please provide details:

--

6. Have you sought medical treatment or advice for asthma? Yes No

If **yes**, please provide details:

Name of doctor/health professional		
Address		
Suburb/town	State	Postcode
Date of last consultation	/	/

7. How has your doctor described your asthma? Mild Moderate Severe

8. Have you ever used any medication, including steroids? Yes No

If **yes**, please provide details:

Type	Date commenced	Frequency (e.g. daily, weekly, etc.)	Dosage	Date ceased (if applicable)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

9. Have you ever been hospitalised due to asthma? Yes No

If **yes**, please provide details:

Date from	/	/	Date to	/	/
Name and address of hospital:					

10. Have you ever had lung function tests performed? Yes No

If **yes**, please provide details:

Date	Test results
/ /	
/ /	

Blood pressure questionnaire

Only complete this questionnaire if you answered **yes** to question 2 in section 8.

1. When was your high blood pressure first diagnosed?

Date diagnosed / /

2. What was your blood pressure reading at that time?

Systolic Diastolic

3. Have you ever been treated by medication?

Yes No

If **yes**, please provide details:

Type	Date commenced	Frequency (e.g. daily, weekly, etc.)	Dosage	Date ceased (if applicable)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

4. Did you undergo any tests or investigations? Yes No

If **yes**, please provide details:

Test performed	Date	Results
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor? Yes No

If **yes**, please provide details:

Name		
Address		
Suburb/town	State	Postcode
Date of last consultation / /		

6. What was the date of your last blood pressure check?

Date / /

7. What was your blood pressure reading at that time?

Systolic Diastolic

8. How has your doctor described your blood pressure control?

Excellent

Good

Poor

Other

If **other**, please provide details

9. When is your next blood pressure check-up?

Date / /

Cholesterol questionnaire

Only complete this questionnaire if you answered **yes** to question 3 in section 8.

1. When was your high cholesterol first diagnosed?

Date diagnosed / /

2. What were your cholesterol readings at that time?

Cholesterol Triglycerides

HDL Cholesterol LDL Cholesterol

3. Did you undergo any tests or investigations? Yes No

If **yes**, please provide details:

Test performed	Date	Results
	/ /	
	/ /	

4a. Have you ever used any medication? Yes No

If **yes**, please provide details:

Type	Date commenced	Frequency (e.g. daily, weekly, etc.)	Dosage	Date ceased (if applicable)	Reason for cessation
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	
	/ /			/ /	

b. Has this treatment ever changed (e.g. has the type or dosage of your medication been changed)? Yes No

If **yes**, please provide date of when treatment changed and the reason(s) for change:

5. Is the treating doctor different to your usual doctor? Yes No

If **yes**, please provide details:

Name		
Address		
Suburb/town	State	Postcode
Date of last consultation / /		

6. What was the date of your last cholesterol check?

Date	/	/
------	---	---

7. What were your cholesterol readings at that time?

Cholesterol	Triglycerides
LDL Cholesterol	HDL Cholesterol

8. How has your doctor described your cholesterol control?

Excellent Good Poor Other

If **other**, please provide details

9. When is your next cholesterol check up?

Date	/	/
------	---	---

Diabetes questionnaire

Only complete this questionnaire if you answered **yes** to question 4 in section 8.

1. When was your diabetes first diagnosed?

Date diagnosed	/	/
----------------	---	---

2. How is your diabetes controlled?

- insulin – go to question 3
- diet only – go to question 4
- oral – list medications below and then go to question 4

3. How many times a day do you administer insulin?

- I'm on an insulin pump
- One or two times daily
- Three or more times daily

4. How often do you monitor your sugar levels? One or two times daily Three or more times daily Other

If **other**, please provide details

5. Have you ever had insulin reactions, diabetic coma, heart, kidney, peripheral vascular disease or eye problems (not already mentioned in the Personal Statement), or protein in the urine? Yes No

If **yes**, please provide details:

Condition	Date	Treatment
	/ /	
	/ /	

6. Have you had a glycosylated haemoglobin (HbA1c) test in the last six months? Yes No

If **yes**, please provide details:

Date	Test Results
/ /	
/ /	

Is this result consistent with others taken over the last 12 months? Yes No

If **no**, please provide details:

Date	Test Results
/ /	
/ /	

7. Is the treating doctor different to your usual doctor? Yes No

If **yes**, please provide details:

Name		
Address		
Suburb/town	State	Postcode
Date of last consultation / /		

Mental health questionnaire

Only complete this questionnaire if you answered **yes** to question 5 in section 8.

1. Please tick the conditions you have had (or currently have), or received treatment for:

- Anxiety including generalised anxiety, panic or phobia disorder
- Eating disorder including anorexia nervosa, bulimia
- Depression including major depression, dysthymia
- Manic depressive illness, bi-polar disorder
- Alcohol or other substance abuse or addiction
- Post traumatic stress
- Schizophrenia or any other psychotic disorder
- Stress, sleeplessness, chronic tiredness
- Other

2. Please complete the table below for all described conditions:

Condition	Describe your symptoms	Date diagnosed	Date condition ceased (if applicable)
		/ /	/ /
		/ /	/ /
		/ /	/ /
		/ /	/ /

3. Have you ever had any recurrence of the symptoms? Yes No

If **yes**, please provide details including dates:

4. Are you currently symptom free? Yes No

If **yes**, please provide date(s) of last symptoms:

--

5. Have you ever attempted suicide or self harm? Yes No

If **yes**, please provide details including when, name and address of treating doctor, clinic or hospital:

6. Are you aware of the cause or reason for your condition(s)? Yes No

If **yes**, please provide details:

7. Have you ever had any time off work due to this condition? Yes No

If **yes**, please provide the dates and duration:

8. Are you currently or have you ever been on treatment, including medication? Yes No

If **yes**, please provide details:

Treatment (e.g. tranquilisers, sedatives, ECT, counselling, etc.)	Date commenced	Date ceased (if applicable)	Reason ceased
	/ /	/ /	
	/ /	/ /	

9. Do you feel that this condition has had any impact on your ability to perform your job at work or on your social life? Yes No

If **yes**, please provide details:

10. Have you been referred for consultation with a psychiatrist or psychologist? Yes No

If **yes**, please provide details:

Name of consultant		
Address		
Suburb/town	State	Postcode
Date of consultation / /		

11. Have you been admitted to hospital or any other care facility? Yes No

If **yes**, please provide details:

Name of institution		
Address		
Suburb/town	State	Postcode
Date of consultation / /	Doctors consulted	

Back/neck questionnaire

Only complete this questionnaire if you answered **yes** to question 6 in section 8.

1. When did your back/neck condition first occur?

Date	/	/
------	---	---

2. Which area(s) of your back/neck was affected (e.g. middle back)?

--

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including the symptoms and doctor's diagnosis if known (e.g. sciatica, prolapsed disc, whiplash etc.):

5. Was an X-ray, CT scan or any other type of investigation performed? Yes No

If **yes**, please provide details:

Tests	Results	Date of tests
		/ /
		/ /

6. Have you had recurrent or multiple episodes of the back/neck condition? Yes No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration:

--

7. Please provide details of all people you have consulted for this condition in the table below:

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist etc.)	Date last consulted	Treatment prescribed (e.g. analgesics, anti-inflammatory drugs, immobilisation etc.)
		/ /	
		/ /	
		/ /	

8. Have you had any time off work due to this condition? Yes No

If **yes**, please provide the dates and duration:

9. Are your work duties or activities limited/affected by the condition? Yes No

If **yes**, please provide details:

10. Are you still undergoing treatment or do you have any residual pain, limitation of movement or restriction of any kind? Yes No

If **yes**, please provide details:

11. Overall do you feel that your back/neck condition is: Resolved Improving Stable Deteriorating

12. What was the date of your last symptoms?

Date	/	/
------	---	---

Arthritis/joint questionnaire

Only complete this questionnaire if you answered **yes** to question 7 in section 8.

1. Which joint is/was affected (please tick relevant box/es)? If more than one box ticked, please copy this questionnaire and complete for each condition.

Left	Right	Left	Right
Ankle	<input type="checkbox"/> <input type="checkbox"/>	Knee	<input type="checkbox"/> <input type="checkbox"/>
Elbow	<input type="checkbox"/> <input type="checkbox"/>	Wrist	<input type="checkbox"/> <input type="checkbox"/>
Shoulder	<input type="checkbox"/> <input type="checkbox"/>	Hip	<input type="checkbox"/> <input type="checkbox"/>
Other	<input type="checkbox"/> <input type="checkbox"/>	If other , state which joint	

2. When did this condition first occur?

Date / /

3. What was the cause or reason for the condition?

4. Please describe the exact nature of the condition, including symptoms and doctor's diagnosis if known:

5. Have you had recurrent or multiple episodes of the condition? Yes No

If **yes**, please provide details including the number of episodes and the date of the most recent episode including duration:

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6. Please provide details of all people you have consulted for this condition in the table below:

Name and address of doctor/health professional	Type (e.g. doctor, chiropractor, physiotherapist etc.)	Date last consulted	Treatment prescribed (e.g. steroids, anti-inflammatory drugs, surgery, acupuncture, etc.)
		/ /	
		/ /	
		/ /	

7. Have you had any time off work due to this condition? Yes No

If **yes**, please provide the dates and duration:

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8. Do you have any residual pain, limitation of movement or restriction of any kind? Yes No

If **yes**, please provide details:

9. Are your work duties or activities limited/affected by the condition? Yes No

If **yes**, please provide details:

10. Are you still undergoing treatment? Yes No

If **yes**, please provide details:

11. Overall do you feel that your condition is: Resolved Improving Stable Deteriorating

12. What was the date of your last symptoms?

Date / /

Cyst/mole/skin lesion questionnaire

Only complete this questionnaire if you answered **yes** to question 8 in section 8.

1. Please provide details in the table below:

Site (e.g. back, left leg, etc.)	Date diagnosed	Type (e.g. basal cell carcinoma, melanoma, cyst, mole, etc.)	Pathology results (e.g. malignant, benign, unknown, etc.)
	/ /		
	/ /		
	/ /		

2. Was the cyst/mole/skin lesion(s) removed? Yes No

If **yes**, please provide details for each:

Date of removal / /

By what method (e.g. surgically, frozen or burnt off)?

If **no**, please provide details including date set for removal, if applicable

3. Have you been or are you required to attend any further treatment or regular follow up since the original removal? Yes No

If **yes**, please provide details and advise how often follow up is required:

4. Have you had any other tests, investigations or treatments not mentioned above? Yes No

If **yes**, please provide details:

Tests/treatments/investigations	Date	Results
	/ /	
	/ /	
	/ /	
	/ /	

5. Is the treating doctor different to your usual doctor? Yes No

If **yes**, please provide details:

Name		
Address		
Suburb/town	State	Postcode
Date of last consultation / /		

