DEPRESSION

Client's Name ______________________________________

If your client has a history of depression, please answer the following:

1. Please list the diagnosis______________________________________

2. Please indicate the number of episodes and date of last episode:

   ____

3. Is your client on any medications?
   ☐ yes, please list all medicines:______________________________
   ☐ no

4. Has your client ever been hospitalized for treatment of depression?
   ☐ yes, please give details ______________________________
   ☐ no

5. Has your client ever received ECT ("Shock Treatment")?
   ☐ yes, please give dates ______________________________
   ☐ no

6. Does your client have a history of any of the following associated conditions (check all that pply)?

	Yes, please give details	No
Substance abuse (alcohol or drugs)	☐ ________________	☐
Personality disorder	☐ ________________	☐
Psychotic disorder	☐ ________________	☐
Suicidal though/attempt	☐ ________________	☐

7. Does your client have any other major health problems (example: heart disease, stroke, cancer, etc.)?
   ☐ yes, please give details ______________________________
   ☐ no

Agents name: Agents Tell # Agent Fax #
Date Submitted: Agents e-mail address:

PLEASE FAX TO BEST MARKETING AT 1-781 643-2775