

# NEW SS CLIENT QUESTIONNAIRE

Name: \_\_\_\_\_

Today's Date: \_\_\_\_\_

*Put "N/A" as an answer to any question that does not apply to you.*

*Please use additional paper where necessary, and attach to the back of the packet, noting the number of the question.*

## I. Application Information

1. When did you apply for disability benefits?

SSDI: \_\_\_\_\_

SSI: \_\_\_\_\_

2. In your (current) application(s) for benefits, what is the date you stated that you became unable to work?

\_\_\_\_\_

3. Are you a U.S. citizen?       Yes       No

4. If you have previously applied for benefits, please list:

Date(s) of previous application (approximate if unsure): \_\_\_\_\_

Types of benefits applied for:       SSDI       SSI

Did your case get to a judge?  Yes       No

If yes, did you receive an unfavorable decision from a judge?       Yes       No

If yes, did you appeal this decision?       Yes       No

## II. Work History

5. When did you stop working? \_\_\_\_\_

6. Why did you stop working? \_\_\_\_\_

7. Why can't you work now? \_\_\_\_\_

8. Are you working now?       Yes       No

If yes, where? \_\_\_\_\_

If working now, earnings per month *before taxes* \$ \_\_\_\_\_

9. Have you worked anywhere since you became disabled?       Yes       No

When? \_\_\_\_\_

Where? \_\_\_\_\_

What job? \_\_\_\_\_

Why did the job end? \_\_\_\_\_

If worked since disability started, earnings per month *before taxes* \$ \_\_\_\_\_

10. Have you ever lost or quit a job because of your limitations?       Yes       No

If yes, please explain why you lost the job: \_\_\_\_\_

11. Have you applied for any jobs since the date you became unable to work?       Yes       No

If yes, what job did you apply for? \_\_\_\_\_

Why did you think you would be able to do this job?

\_\_\_\_\_

\_\_\_\_\_

12. Are there any of your previous jobs you think you might be able to do?       Yes       No

If yes, which one(s)? \_\_\_\_\_

13. Were you ever in the military?       Yes       No

Branch: \_\_\_\_\_

Dates of service: \_\_\_\_\_

Highest Rank: \_\_\_\_\_

Nature of discharge: \_\_\_\_\_

Describe any special training: \_\_\_\_\_

## EMPLOYMENT HISTORY

Please provide information for all employment 15 years prior to the date you became disabled.  
Attach a resume if available. Please fill in any information not covered in your resume.

Job Title	Employer	Dates of Employment	Hours worked per week	Wage
1)	Name:  Address:  Phone:			\$____ per month  \$____ per week  \$____ per hour
2)	Name:  Address:  Phone:			\$____ per month  \$____ per week  \$____ per hour
3)	Name:  Address:  Phone:			\$____ per month  \$____ per week  \$____ per hour
4)	Name:  Address:  Phone:			\$____ per month  \$____ per week  \$____ per hour
5)	Name:  Address:  Phone:			\$____ per month  \$____ per week  \$____ per hour

## EMPLOYMENT HISTORY (CONT.)

Job Title	Employer	Dates of Employment	Hours worked per week	Wage
6)	Name:  Address:  Phone:			\$____ per month  \$____ per week  \$____ per hour
7)	Name:  Address:  Phone:			\$____ per month  \$____ per week  \$____ per hour
8)	Name:  Address:  Phone:			\$____ per month  \$____ per week  \$____ per hour
9)	Name:  Address:  Phone:			\$____ per month  \$____ per week  \$____ per hour
10)	Name:  Address:  Phone:			\$____ per month  \$____ per week  \$____ per hour

**For each job listed above, please provide the following details:**

1) Job Description: \_\_\_\_\_

1. Job duties:  
\_\_\_\_\_  
\_\_\_\_\_

2. Did you use tools at this job?  yes  no  
If so, describe: \_\_\_\_\_

3. Did you use office equipment/machines at this job?  yes  no  
If so, describe: \_\_\_\_\_

4. Did you use other equipment/machines at this job?  yes  no  
If so, describe: \_\_\_\_\_

5. Did you read plans at this job?  yes  no  
If so, describe: \_\_\_\_\_

6. Did you supervise people at this job?  yes  no  
If so, number of people: \_\_\_\_\_  
Were you responsible for hiring/firing?  yes  no  
Were you responsible for scheduling?  yes  no  
Were you responsible for discipline?  yes  no

7. During each work shift, how long did you perform the following activities:  
Sit: \_\_\_\_\_  
Stand: \_\_\_\_\_  
Walk: \_\_\_\_\_  
Total Hours per shift: \_\_\_\_\_

8. How much did you carry on an occasional basis? (occasional= 2-3 hours per day)  
*As a reference point, a gallon of milk weighs approximately 8 lbs.*  
 less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

9. How much did you carry on a frequent basis? (frequent= 3+ hours per day)  
*As a reference point, a gallon of milk weighs approximately 8 lbs.*  
 less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

2) Job Description: \_\_\_\_\_

1. Job duties:

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2. Did you use tools at this job?  yes  no

If so, describe: \_\_\_\_\_

3. Did you use office equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

4. Did you use other equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

5. Did you read plans at this job?  yes  no

If so, describe: \_\_\_\_\_

6. Did you supervise people at this job?  yes  no

If so, number of people: \_\_\_\_\_

Were you responsible for hiring/firing?  yes  no

Were you responsible for scheduling?  yes  no

Were you responsible for discipline?  yes  no

7. During each work shift, how long did you perform the following activities:

Sit: \_\_\_\_\_

Stand: \_\_\_\_\_

Walk: \_\_\_\_\_

Total Hours per shift: \_\_\_\_\_

8. How much did you carry on an occasional basis? (occasional= 2-3 hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

9. How much did you carry on a frequent basis? (frequent= 3+ hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

3) Job Description: \_\_\_\_\_

1. Job duties:

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2. Did you use tools at this job?  yes  no

If so, describe: \_\_\_\_\_

3. Did you use office equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

4. Did you use other equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

5. Did you read plans at this job?  yes  no

If so, describe: \_\_\_\_\_

6. Did you supervise people at this job?  yes  no

If so, number of people: \_\_\_\_\_

Were you responsible for hiring/firing?  yes  no

Were you responsible for scheduling?  yes  no

Were you responsible for discipline?  yes  no

7. During each work shift, how long did you perform the following activities:

Sit: \_\_\_\_\_

Stand: \_\_\_\_\_

Walk: \_\_\_\_\_

Total Hours per shift: \_\_\_\_\_

8. How much did you carry on an occasional basis? (occasional= 2-3 hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

9. How much did you carry on a frequent basis? (frequent= 3+ hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

4) Job Description: \_\_\_\_\_

1. Job duties:

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2. Did you use tools at this job?  yes  no

If so, describe: \_\_\_\_\_

3. Did you use office equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

4. Did you use other equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

5. Did you read plans at this job?  yes  no

If so, describe: \_\_\_\_\_

6. Did you supervise people at this job?  yes  no

If so, number of people: \_\_\_\_\_

Were you responsible for hiring/firing?  yes  no

Were you responsible for scheduling?  yes  no

Were you responsible for discipline?  yes  no

7. During each work shift, how long did you perform the following activities:

Sit: \_\_\_\_\_

Stand: \_\_\_\_\_

Walk: \_\_\_\_\_

Total Hours per shift: \_\_\_\_\_

8. How much did you carry on an occasional basis? (occasional= 2-3 hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

9. How much did you carry on a frequent basis? (frequent= 3+ hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

5) Job Description: \_\_\_\_\_

1. Job duties:

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2. Did you use tools at this job?  yes  no

If so, describe: \_\_\_\_\_

3. Did you use office equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

4. Did you use other equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

5. Did you read plans at this job?  yes  no

If so, describe: \_\_\_\_\_

6. Did you supervise people at this job?  yes  no

If so, number of people: \_\_\_\_\_

Were you responsible for hiring/firing?  yes  no

Were you responsible for scheduling?  yes  no

Were you responsible for discipline?  yes  no

7. During each work shift, how long did you perform the following activities:

Sit: \_\_\_\_\_

Stand: \_\_\_\_\_

Walk: \_\_\_\_\_

Total Hours per shift: \_\_\_\_\_

8. How much did you carry on an occasional basis? (occasional= 2-3 hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

9. How much did you carry on a frequent basis? (frequent= 3+ hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

6) Job Description: \_\_\_\_\_

1. Job duties:

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2. Did you use tools at this job?  yes  no

If so, describe: \_\_\_\_\_

3. Did you use office equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

4. Did you use other equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

5. Did you read plans at this job?  yes  no

If so, describe: \_\_\_\_\_

6. Did you supervise people at this job?  yes  no

If so, number of people: \_\_\_\_\_

Were you responsible for hiring/firing?  yes  no

Were you responsible for scheduling?  yes  no

Were you responsible for discipline?  yes  no

7. During each work shift, how long did you perform the following activities:

Sit: \_\_\_\_\_

Stand: \_\_\_\_\_

Walk: \_\_\_\_\_

Total Hours per shift: \_\_\_\_\_

8. How much did you carry on an occasional basis? (occasional= 2-3 hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

9. How much did you carry on a frequent basis? (frequent= 3+ hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

7) Job Description: \_\_\_\_\_

1. Job duties:

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2. Did you use tools at this job?  yes  no

If so, describe: \_\_\_\_\_

3. Did you use office equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

4. Did you use other equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

5. Did you read plans at this job?  yes  no

If so, describe: \_\_\_\_\_

6. Did you supervise people at this job?  yes  no

If so, number of people: \_\_\_\_\_

Were you responsible for hiring/firing?  yes  no

Were you responsible for scheduling?  yes  no

Were you responsible for discipline?  yes  no

7. During each work shift, how long did you perform the following activities:

Sit: \_\_\_\_\_

Stand: \_\_\_\_\_

Walk: \_\_\_\_\_

Total Hours per shift: \_\_\_\_\_

8. How much did you carry on an occasional basis? (occasional= 2-3 hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

9. How much did you carry on a frequent basis? (frequent= 3+ hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

8) Job Description: \_\_\_\_\_

1. Job duties:

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2. Did you use tools at this job?  yes  no

If so, describe: \_\_\_\_\_

3. Did you use office equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

4. Did you use other equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

5. Did you read plans at this job?  yes  no

If so, describe: \_\_\_\_\_

6. Did you supervise people at this job?  yes  no

If so, number of people: \_\_\_\_\_

Were you responsible for hiring/firing?  yes  no

Were you responsible for scheduling?  yes  no

Were you responsible for discipline?  yes  no

7. During each work shift, how long did you perform the following activities:

Sit: \_\_\_\_\_

Stand: \_\_\_\_\_

Walk: \_\_\_\_\_

Total Hours per shift: \_\_\_\_\_

8. How much did you carry on an occasional basis? (occasional= 2-3 hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

9. How much did you carry on a frequent basis? (frequent= 3+ hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

9) Job Description: \_\_\_\_\_

1. Job duties:

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2. Did you use tools at this job?  yes  no

If so, describe: \_\_\_\_\_

3. Did you use office equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

4. Did you use other equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

5. Did you read plans at this job?  yes  no

If so, describe: \_\_\_\_\_

6. Did you supervise people at this job?  yes  no

If so, number of people: \_\_\_\_\_

Were you responsible for hiring/firing?  yes  no

Were you responsible for scheduling?  yes  no

Were you responsible for discipline?  yes  no

7. During each work shift, how long did you perform the following activities:

Sit: \_\_\_\_\_

Stand: \_\_\_\_\_

Walk: \_\_\_\_\_

Total Hours per shift: \_\_\_\_\_

8. How much did you carry on an occasional basis? (occasional= 2-3 hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

9. How much did you carry on a frequent basis? (frequent= 3+ hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

10) Job Description: \_\_\_\_\_

1. Job duties:

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2. Did you use tools at this job?  yes  no

If so, describe: \_\_\_\_\_

3. Did you use office equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

4. Did you use other equipment/machines at this job?  yes  no

If so, describe: \_\_\_\_\_

5. Did you read plans at this job?  yes  no

If so, describe: \_\_\_\_\_

6. Did you supervise people at this job?  yes  no

If so, number of people: \_\_\_\_\_

Were you responsible for hiring/firing?  yes  no

Were you responsible for scheduling?  yes  no

Were you responsible for discipline?  yes  no

7. During each work shift, how long did you perform the following activities:

Sit: \_\_\_\_\_

Stand: \_\_\_\_\_

Walk: \_\_\_\_\_

Total Hours per shift: \_\_\_\_\_

8. How much did you carry on an occasional basis? (occasional= 2-3 hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

9. How much did you carry on a frequent basis? (frequent= 3+ hours per day)

*As a reference point, a gallon of milk weighs approximately 8 lbs.*

less than 10 lbs.  10 lbs.  20 lbs.  50 lbs.  100 lbs.

### III. Education

1. Are you currently attending school, or planning to attend school within the next 12 months?

Yes  No

If yes, what is the name of the school? \_\_\_\_\_

Course of study: \_\_\_\_\_

2. What is the highest grade you have completed in school? \_\_\_\_\_

If you attended college, list degree(s) attained, and major course of study: \_\_\_\_\_

3. When did you last go to school? \_\_\_\_\_

4. Did you repeat any grades?  Yes  No

5. Were you in special classes?  Yes  No

If yes, describe: \_\_\_\_\_

6. If you left school before completing high school,

Did you get a GED?  Yes  No

When? \_\_\_\_\_

What was the reason for leaving school? \_\_\_\_\_

7. How well do you read?

Above-average  Average  Below Average  Illiterate/unable to read English

If below average or illiterate,

Are you able to read a menu or list?  Yes  No

Are you able to read simple instructions?  Yes  No

8. Has your reading been tested?  Yes  No

If yes, who tested you and what were the results: \_\_\_\_\_

\_\_\_\_\_

9. Are you able to do the following mathematics?

Make Change  Yes  No

Decimals/Fractions  Yes  No

Add and Subtract  Yes  No

Multiply and Divide  Yes  No

Higher Mathematics  Yes  No

10. For any vocational training you have had in your life, please identify:

the school: \_\_\_\_\_

the type of training: \_\_\_\_\_

dates attended: \_\_\_\_\_

whether you completed the program:  Yes  No

11. Have you ever been evaluated by the state vocational rehabilitation agency?  Yes  No

If yes, please provide your vocational rehabilitation counselor's name, address and the dates you were

seen: \_\_\_\_\_

\_\_\_\_\_

## IV. Medical Information

1. List your health conditions	When did each condition first bother you

2. Current height: \_\_\_\_\_

3. Current weight: \_\_\_\_\_

4. What is your usual weight? \_\_\_\_\_

5. When was the last time you weighed this much? \_\_\_\_\_

6. Do you smoke?       Yes       No

If yes, how much? \_\_\_\_\_

7. Have you ever had any problems with drug abuse?    Yes       No

8. Have you ever been treated for drug abuse?    Yes       No

If yes, when and where? \_\_\_\_\_

When did you last use drugs? \_\_\_\_\_

9. Have you ever had any problems with alcohol abuse?    Yes       No

10. Have you ever been treated for alcohol abuse?    Yes       No

If yes, when and where? \_\_\_\_\_

When did you last use alcohol? \_\_\_\_\_

**Current Medical Problems:**

11. Since the date you became disabled have you been getting better or worse?  
 Better       Worse       Same

12. Has any doctor told you not to work?       Yes       No

If yes, who? \_\_\_\_\_

13. Has any doctor told you to limit your activities?       Yes       No

If yes, please describe the limitations: \_\_\_\_\_

\_\_\_\_\_

Which doctor(s) told you this? \_\_\_\_\_

14. Do you have a handicapped parking permit?  Yes       No

If yes, which doctor signed the papers for it? \_\_\_\_\_

15. Which doctor (past or present) knows the most about your conditions and disability? \_\_\_\_\_

16. Do you have any current problem with any of the following?

Shortness of breath       Yes  No

Coughing up blood       Yes  No

Hot/cold flashes       Yes  No

Excessive sweating       Yes  No

Heart palpitations       Yes  No

Diarrhea       Yes  No

Controlling your urine       Yes  No

High blood pressure       Yes  No

Dizziness       Yes  No

Swelling of feet/ankles       Yes  No

Blackouts       Yes  No

Fatigue       Yes  No

Difficulty sleeping             Yes  No

Recent weight loss             Yes  No

Recent weight gain             Yes  No

Vision                             Yes  No

If yes, please explain the nature of your vision problems: \_\_\_\_\_

\_\_\_\_\_

Is the vision problem correctable with glasses?     Yes  No

**Pain:**

17. If your disability involves pain, answer the following: (If pain is not your problem, skip this section)

18. Approximate date pain began: \_\_\_\_\_

19. What events caused the pain (accident, disease, surgery, unknown)? \_\_\_\_\_

20. What does your pain feel like (e.g. sharp, stabbing, throbbing, dull ache)? \_\_\_\_\_

\_\_\_\_\_

21. Does pain     lessen or     increase    when you push on the painful spots?

22. Are any of the following associated with your pain? Check those that apply:

Numbness

Increased sweating

Nausea

Loss of concentration

Tingling (pins and needles)

Muscle spasm

Loss of sleep

Depression

- Weakness
- Skin discoloration
- Crying spells
- Agitation

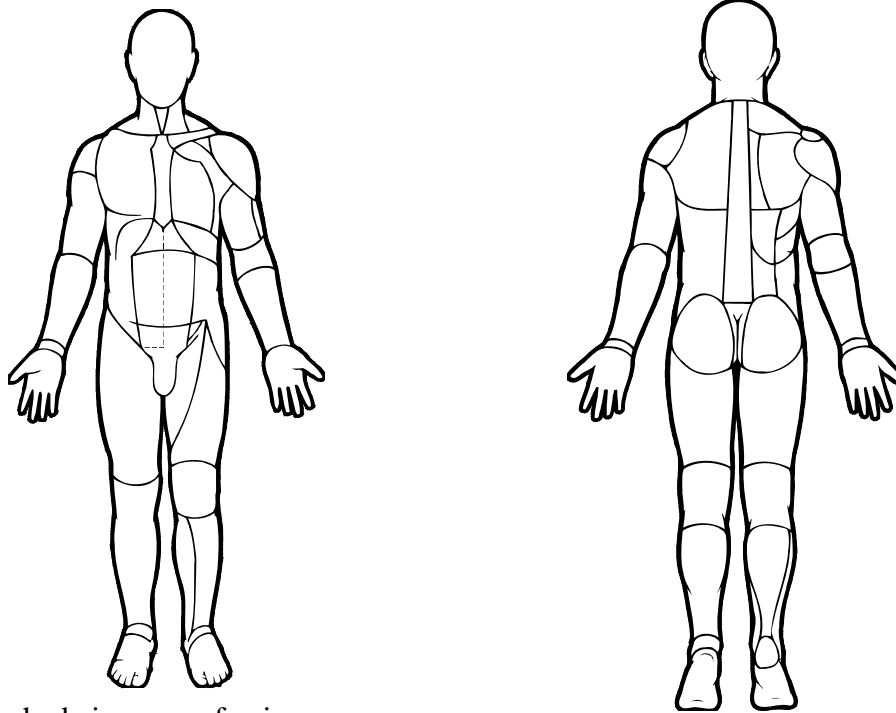
23. Is your pain:  Constant?  Often?  Occasional?

24. How many hours per day do you have pain? \_\_\_\_\_

25. If you do not have pain every day, estimate how many hours of pain per week, or days per week or month:

\_\_\_\_\_

26. Location of pain:



Please shade in areas of pain.

BE AS SPECIFIC AS POSSIBLE

27. Below is a list of activities. For each activity indicate how it affects your pain.

	Increases	Decreases	No effect
Lying down	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Rising from sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Coughing/sneezing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Riding in a car	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

28. What else increases your pain?

\_\_\_\_\_

29. Below is a list of treatments you may have used to relieve pain. For each of these, check whether you have tried it and whether it helped.

	Never tried	Tried	Helped	Didn't help
Heat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Massage	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Whirlpool	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Traction	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Prescribed exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
TNS (OR TCS OR TENS, transcutaneous stimulation)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Biofeedback	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Trigger point in injections	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Nerve blocks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Acupuncture	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chiropractic treatments	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Behavior modification	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Counseling	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Back school	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Pain clinic	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Physical therapy	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

30. What other things relieve your pain? \_\_\_\_\_

31. How much and how often do you drink alcoholic beverages? \_\_\_\_\_

32. Does drinking alcoholic beverages relieve your pain?  Yes  No

33. Rate your pain by circling the **one** number that **best** describes it.

*\*A rating of 10 would indicate pain so severe that you would have to be taken to the emergency room immediately.*

0	1	2	3	4	5	6	7	8	9	<b>10*</b>
None		Moderate						Very Severe		

34. How much does the pain interfere with your activities? Circle the **one** number that **best** describes the amount of interference.

*\*A rating of 10 would indicate you must lie down all of the time and cannot do **anything**.*

0	1	2	3	4	5	6	7	8	9	<b>10*</b>
None		Moderate						Very Severe		

**Doctors who have treated you:**

35. For each doctor or chiropractor you have seen, please complete the following chart.

*List the doctors you are seeing now first and work your way back to about five years before you became unable to work.*

Name and address of doctor	Date of first visit (approximate)	Date of last visit (approximate)	Which condition was treated	Describe any restriction of activities imposed or what you were told about your condition

Please use additional paper, if necessary.

**SSA Doctors**

36. For each doctor, psychologist or psychiatrist the Social Security Administration sent you to, please complete the following:

Name of doctor	Doctor's specialty	Date of exam (approximate)	Length of exam (min.)	Describe anything doctor told you about your condition

**Hospitalizations:**

37. For each hospitalization (where you stayed at least one night), please complete the following chart (**please include any psychiatric hospitalizations as well**).

*List your most recent hospitalizations first and work your way back to about five years before you became unable to work.*

Name and address of hospital	Approximate date	Why were you hospitalized

Please use additional paper, if necessary.

**Outpatient Hospitalizations:**

38. For each outpatient visit to a hospital, diagnostic center, rehabilitation center or physical therapy clinic, (for example, for emergency room care, physical therapy or other treatment, diagnostic tests, etc.) please complete the following chart (**please include any outpatient psychiatric hospitalizations as well**).

*List your most recent outpatient hospitalizations first and work your way back to about five years before you became unable to work.*

Name and address of hospital or clinic	Approximate date of treatment	What were you treated for

Please use additional paper, if necessary.

**Psychologists and Psychiatrists:**

39. For each psychologist or psychiatrist you have seen, please complete the following chart.

*List the providers you are seeing now first and work your way back to about five years before you became unable to work.*

Name and address of provider	Date of first visit (approximate)	Date of last visit (approximate)

Please use additional paper, if necessary.

**Counselors or Social Workers:**

40. For each counselor or social worker you have seen, please complete the following chart.

*List the providers you are seeing now first and work your way back to about five years before you became unable to work.*

Name and address of provider	Date of first visit (approximate)	Date of last visit (approximate)

## V. Daily Activities

1. How much time do you spend each day doing things while:	Hours per day
Sleep/stay in bed	
Sleep/lie on couch	
Lying down or reclining in recliner	
Sitting upright	
Standing/walking	
Total hours per day:	<b>24</b>

2. How well do you sleep?     Good     Fair     Poor

3. How many hours per night do you sleep? \_\_\_\_\_

4. Please check what you do and how often. If you need help or do a poor job please indicate. Give examples as appropriate.

Activity	Several times a day	Daily	Weekly	Monthly	Never	Someone else does this	Examples-Need help, can do but only with breaks, etc...
Drive	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Cook	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Wash dishes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Straighten up house	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Dust	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Vacuum	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Do laundry	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Mop floor	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Clean bathroom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Make bed	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

Activity	Several times a day	Daily	Weekly	Monthly	Never	Someone else does this	Examples-Need help, can do but only with breaks, etc...
Groom self	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Yard work	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Gardening	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Shovel snow	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Fix things	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Grocery shop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Pay bills, handle finances	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Watch children	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Participate in organizations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Attend religious services	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Attend sports events	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Visit relatives or friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Go out to eat or movies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Use public transportation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	
Exercise	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	

5. Does anyone have to help you to do things around the house on a regular basis?  Yes  No

Who? \_\_\_\_\_

What do they do? \_\_\_\_\_

\_\_\_\_\_

**Good days and bad days:**

6. Do you have good days and bad days?  Yes  No

7. Approximately how many days per month are good days? \_\_\_\_\_

8. What tends to produce good days? \_\_\_\_\_

\_\_\_\_\_

9. Please describe what a good day is like (please be as detailed a possible about what you are able to do and not able to do): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Please use additional paper, if necessary.

10. Approximately how many days per month are bad days? \_\_\_\_\_

11. What tends to produce bad days? \_\_\_\_\_

\_\_\_\_\_

12. Please describe what a bad day is like (please be as detailed a possible about what you are able to do and not able to do): \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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Please use additional paper, if necessary.

**Physical limitations:**

NOTE: If your disability is psychiatric, and you have no physical limitations, skip this section and go on to section VI.

**Sitting:**

13. Do you have any trouble sitting?  Yes  No
14. Does it make a difference what kind of chair you sit on?  Yes  No
15. What kind of chair is best for you? \_\_\_\_\_
16. Do you need to elevate your legs while sitting?  Yes  No
17. Where do you have pain or discomfort when you sit too long? \_\_\_\_\_
18. What do you do to relieve that pain or discomfort? \_\_\_\_\_
19. List examples of any activities you have trouble performing while sitting: \_\_\_\_\_  
\_\_\_\_\_
20. How long can you sit continuously in one stretch in a work chair (not a recliner) before you must get up and move around or lie down? Minutes: \_\_\_\_\_ Hours: \_\_\_\_\_
21. If you were sitting on and off throughout a workday, how many hours total out of an eight-hour workday can you sit? Hours: \_\_\_\_\_

**Standing:**

22. Do you have any trouble standing?  Yes  No
23. Where do you have pain or discomfort when you stand too long? \_\_\_\_\_
24. What do you do to relieve that pain or discomfort? \_\_\_\_\_

25. List examples of any activities you have trouble performing while standing: \_\_\_\_\_  
\_\_\_\_\_
26. How long can you stand continuously in one stretch without sitting or walking around?  
Minutes: \_\_\_\_\_ Hours: \_\_\_\_\_
27. If you were standing on and off throughout a workday, how long total out of an eight-hour workday can you stand? Minutes: \_\_\_\_\_ Hours: \_\_\_\_\_

**Walking:**

28. Do you have any trouble walking?  Yes  No
29. Do you ever use a cane or other device to help you walk?  Yes  No
30. Where do you have pain or discomfort when you walk too long? \_\_\_\_\_
31. What do you do to relieve that pain or discomfort? \_\_\_\_\_
32. List examples of any activities you have trouble performing while walking: \_\_\_\_\_  
\_\_\_\_\_
33. How long can you walk continuously in one stretch without stopping to rest?  
Minutes: \_\_\_\_\_ Hours: \_\_\_\_\_
34. If you were walking on and off throughout a workday, how long total out of an eight-hour workday can you walk? Minutes: \_\_\_\_\_ Hours: \_\_\_\_\_

**Lifting and carrying:**

35. Do you have any problem lifting or carrying?  Yes  No
36. What is the heaviest thing that you encounter in your everyday life that you can still lift and carry? (e.g. gallon of milk, 12 pack of soda, bag of groceries, small children)? \_\_\_\_\_
37. What happens when you try to lift or carry too much? \_\_\_\_\_
38. Please give an example of what is too much for you to lift or carry: \_\_\_\_\_

39. List examples of things that you encounter in your daily life that you can no longer lift or carry: \_\_\_\_\_
- 
40. What is the maximum weight you can lift or carry in a regular work situation if you only had to do it once in a while (a gallon of milk weighs about 8 pounds)? \_\_\_\_\_ lbs.
41. What is the maximum weight you can lift or carry in a regular work situation if you had to do it frequently (that is, between 2 hours & 40 minutes to 5 hours & 20 minutes a day)? \_\_\_\_\_ lbs.

**Arms and hands:**

42. Are you left or right handed?  Left  Right
43. Do you have any problems using your hands or arms?  Yes  No
44. Can you make a fist with your right hand?  Yes  No
45. Can you make a fist with your left hand?  Yes  No
46. Can you touch each finger to the thumb on your right hand?  Yes  No
47. Can you touch each finger to the thumb on your left hand?  Yes  No
48. Do your hands shake?  Yes  No
49. Do you have any trouble with your hands being numb or having pins and needles?  Yes  No
50. Do you have trouble with dropping things?  Yes  No
51. Have you lost strength in your right hand/arm?  Yes  No
52. Have you lost strength in your left hand/arm?  Yes  No
53. Do you have any trouble reaching above your head (for example to put things away in kitchen cupboards)?   
 Yes  No
54. Do you have any problems using your hands to drive a car?  Yes  No  
 If yes, please explain: \_\_\_\_\_
55. Do you have any problems writing a letter?  Yes  No  
 If yes, please explain: \_\_\_\_\_

56. Do you have any problems using a computer-either keyboard or mouse?  Yes  No

If yes, please explain: \_\_\_\_\_

57. List examples of other activities that you have difficulty performing with your hands: \_\_\_\_\_

\_\_\_\_\_

**Legs and feet:**

58. Do you have any problems using your legs or feet?  Yes  No

59. Do you have any trouble using your legs and feet to drive a car?  Yes  No

60. Describe any other difficulty you have using your legs and feet: \_\_\_\_\_

\_\_\_\_\_

**Other physical limitations:**

61. Please note how often you can perform the following activities:

Activity	Can't do at all	Once is okay	A few times per hour is okay	Repetitively is okay
Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Twisting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Squatting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climbing Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Environmental Restrictions:**

62. Please note if you have any difficulty with the following situations, if you have problems, please explain:

Working around unprotected heights: \_\_\_\_\_

Being around moving machinery: \_\_\_\_\_

Exposure to significant heat or cold: \_\_\_\_\_

Exposure to dust, fumes or gases: \_\_\_\_\_

## VI. Psychiatric/Psychological conditions

1. Have you had any of the following tests in the last five years:

MMPI (Minnesota Multiphasic Personality Inventory):  Yes  No

Done by whom and where: \_\_\_\_\_

Approximate date: \_\_\_\_\_

WAIS (Wechsler Adult Intelligence Scale)  Yes  No

Done by whom and where: \_\_\_\_\_

Approximate date: \_\_\_\_\_

Other psychological tests:  Yes  No

Done by whom and where: \_\_\_\_\_

Approximate date: \_\_\_\_\_

2. Please list all of your psychiatric diagnoses:

Diagnosis	By whom	When were you first diagnosed

3. Please place a check mark beside each statement below that describes you:

I have lost interest in my normal activities

I feel nervous or anxious a lot

I sleep fairly well

- I have trouble making my own decisions
- Sometimes I suddenly feel fear or panic
- I like to be with people
- I have trouble understanding directions
- I have considered or attempted suicide
- I lack confidence
- I am sad most of the time
- I am unable to pay attention to activities I like
- I have been told in the past two years that I should cut down or stop using alcohol or drugs
- People make me happy
- I make bad decisions in a work setting
- I have trouble remembering recent things
- I sleep too much
- I am intelligent
- I have hope for my future
- I hear voices or see things that other people do not see or hear
- I sometimes use alcohol or street drugs to make myself feel better
- I sometimes overuse my prescription medications to help make myself feel better
- I am basically a happy person despite all of my problems
- I can do simple jobs or tasks as long as I do not have to deal with a lot of people.
- I depend on others too much
- I feel guilty a lot
- I have trouble getting along with family, neighbors or others
- I have trouble with my temper

- I do not trust people
- I could do some jobs but people will not hire me
- Sometimes I lose control of my body parts
- People are out to get me
- I have difficulty dealing with normal stress
- My doctors have told me that I am in good physical health
- I think I have a serious undiagnosed illness
- My appetite or eating has changed since I became disabled
- I have racing or confusing thoughts
- I know things will get better
- My thinking is slowed down
- I suffer from anxiety attacks

4. Explain why you are not able to complete a regular work week (5 days a week) without your mental problems interfering: \_\_\_\_\_

\_\_\_\_\_

5. Describe any critical events in your life that contributed to your mental problems (e.g. accidents, victim of crime or abuse, etc.):

\_\_\_\_\_

6. Please complete the following sentences:

I have trouble concentrating and paying attention when: \_\_\_\_\_

\_\_\_\_\_

If I had a job, I would need special help from a supervisor to get simple tasks completed because: \_\_\_\_\_

\_\_\_\_\_

I am not able to understand and follow simple instructions on a job because: \_\_\_\_\_

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My mental problems would not allow me to work because: \_\_\_\_\_

---

Examples of how my habits have deteriorated are: \_\_\_\_\_

---

The biggest difficulty I would have on a job is: \_\_\_\_\_

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What makes me the happiest is: \_\_\_\_\_

---

I am afraid of: \_\_\_\_\_

---

What I like best about myself is: \_\_\_\_\_

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I get angry with myself when I: \_\_\_\_\_

## VII. General Information

1. Are you married?  Yes  No

If you are married, does your spouse work?  Yes  No

Spouse's monthly income *before taxes*: \$ \_\_\_\_\_

Does your spouse receive disability benefits?  Yes  No

If yes, please mark which type he/she receives:  SSI  SSDI  Long Term Disability  VA benefits

Amount of your spouse's monthly benefits: \$ \_\_\_\_\_

2. If you are living with another adult (besides a spouse), does he/she work?  Yes  No

Monthly income, *before taxes*, of person you are living with: \$ \_\_\_\_\_

3. Do you have any minor children (living with you or not living with you)?  Yes  No

If yes, number of minor children: \_\_\_\_\_

4. If you have been receiving any of the following benefits since you became disabled, please note the monthly amount received, and when you first started receiving benefits:

Aid to the Needy and Disabled (A.N.D.)

amount of mo. benefits: \$ \_\_\_\_\_ date benefits started: \_\_\_\_\_

date benefits ended, if applicable: \_\_\_\_\_

Workers' Compensation

amount of mo. benefits: \$ \_\_\_\_\_ date benefits started: \_\_\_\_\_

date benefits ended, if applicable: \_\_\_\_\_

amount of settlement, if any \$ \_\_\_\_\_ date of settlement: \_\_\_\_\_

Veteran's Benefits

amount of mo. benefits: \$ \_\_\_\_\_ date benefits started: \_\_\_\_\_

Pension-Government

amount of mo. benefits: \$ \_\_\_\_\_ date benefits started: \_\_\_\_\_

Agency benefits received from: \_\_\_\_\_

Pension-Private

amount of mo. benefits: \$ \_\_\_\_\_ date benefits started: \_\_\_\_\_

Company benefits received from: \_\_\_\_\_

Temporary Assistance to Needy Families (T.A.N.F)

amount of mo. benefits: \$ \_\_\_\_\_ date benefits started: \_\_\_\_\_

date benefits ended, if applicable: \_\_\_\_\_

Aid to Families with Dependant Children (A.F.D.C.)

amount of mo. benefits: \$ \_\_\_\_\_ date benefits started: \_\_\_\_\_

date benefits ended, if applicable: \_\_\_\_\_

Child Support:

amount of mo. support: \$ \_\_\_\_\_ date support started: \_\_\_\_\_

date support ended, if applicable: \_\_\_\_\_

Alimony:

amount of mo. support: \$ \_\_\_\_\_ date support started: \_\_\_\_\_

date support ended, if applicable: \_\_\_\_\_

Long Term Disability (LTD)

amount of mo. benefits: \$ \_\_\_\_\_ date benefits started: \_\_\_\_\_

date benefits ended, if applicable: \_\_\_\_\_

Name and address of insurance carrier:

\_\_\_\_\_

Short Term Disability (STD)

amount of mo. benefits: \$ \_\_\_\_\_ date benefits started: \_\_\_\_\_

date benefits ended, if applicable: \_\_\_\_\_

Name and address of insurance carrier:

\_\_\_\_\_

Personal Injury Benefits

amount of mo. benefits: \$ \_\_\_\_\_ date benefits started: \_\_\_\_\_

date benefits ended, if applicable: \_\_\_\_\_

amount of settlement, if any \$ \_\_\_\_\_ date of settlement: \_\_\_\_\_

5. If you have had a Workers' Compensation claim, please provide the following information:

date(s) of injury: \_\_\_\_\_

state in which you were injured: \_\_\_\_\_

injuries sustained: \_\_\_\_\_

name and address of insurance carrier: \_\_\_\_\_

name and address of your attorney, if applicable: \_\_\_\_\_

6. If you have had a personal injury claim, please provide the following information:

date(s) of injury: \_\_\_\_\_

injuries sustained: \_\_\_\_\_

name and address of insurance carrier: \_\_\_\_\_

name and address of your attorney, if applicable: \_\_\_\_\_

7. Have you received any unemployment compensation (UC) since the date you became unable to work?

Yes  No

If yes, what date did you first receive UC benefits? \_\_\_\_\_

8. Have you ever applied for VA disability?  Yes  No

If yes, was it for  service connected, or  non-service connected disability?

Is your VA disability claim pending now?  Yes  No

If yes, please give us the name and address of your representative (if you have one):

\_\_\_\_\_

If you have received a decision from the VA,

What was the percentage rating? \_\_\_\_\_

What was the date of the rating? \_\_\_\_\_

When did benefits begin? \_\_\_\_\_

What were the medical problems that the VA rating was based on? \_\_\_\_\_

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9. Does anyone who does NOT live with you provide your household with part or all of the food and shelter?

Yes  No

If yes, please list:

the person's name: \_\_\_\_\_

relationship to you: \_\_\_\_\_

monthly amount they contribute: \$ \_\_\_\_\_

10. Do you and/or your spouse have more than \$2000 in bank accounts or other investments?  Yes  No

11. Do you and/or your spouse have more than \$3000 in bank accounts or other investments?  Yes  No

12. Do you and/or your spouse own any real property other than the house in which you live?

Yes  No

If yes, please describe the property: \_\_\_\_\_

Is it a rental property?  Yes  No

Do you earn any income from the property?  Yes  No

If yes, what is the monthly amount of income? \$ \_\_\_\_\_

13. Do you and/or your spouse own more than one motorized vehicle, such as automobile, motor home or motorcycle?  Yes  No

If yes, list the please list year, make and model, and estimated value for each of the additional vehicles:

\_\_\_\_\_  
\_\_\_\_\_

14. Where do you currently live:

Apartment

Condominium

Duplex

Trailer

Single-family home

Rooming house

Am currently homeless

15. Do you own or rent?  Own  Rent

16. Are you on the:

Rental Agreement  Yes  No

Mortgage  Yes  No

17. If you are not on the rental agreement or mortgage, what is your relationship to the person who is?

\_\_\_\_\_

18. Are you responsible for a portion of the food and rent?  Yes  No

If yes, please list your monthly share of the expenses:

food: \$ \_\_\_\_\_

rent and utilities: \$ \_\_\_\_\_

19. Is anyone loaning you money so that you can pay your monthly expenses (rent/mortgage, utilities, food)?

If yes, who is loaning you money \_\_\_\_\_

what is your relationship to that person \_\_\_\_\_

how much per month are they loaning you \$ \_\_\_\_\_

20. Is someone else paying for your monthly expenses (rent/mortgage, utilities, food)?

If yes, who is paying the expenses? \_\_\_\_\_

what is your relationship to that person \_\_\_\_\_

how much per month are they paying?

Rent/mortgage: \$ \_\_\_\_\_

Utilities: \$ \_\_\_\_\_

Food: \$ \_\_\_\_\_

21. How many bedrooms are there at your residence? \_\_\_\_\_

22. Please give the names and ages of people living with you and indicate their relationship to you (e.g., son, step-daughter, sister, grandson, friend, etc.). Please include dates of birth for your children:

Name	Relationship	Age	Date of birth (for children)

23. What are the names of the two people with whom you spend the most time? \_\_\_\_\_

\_\_\_\_\_

24. Have you EVER been arrested, convicted or adjudicated of any crime?  Yes  No

If so, please list where you were arrested convicted or adjudicated and the outcome:

\_\_\_\_\_

\_\_\_\_\_

25. Do you have any outstanding warrants for your arrest?

If so, please explain:

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26. Have you been in prison or jail since the date you became disabled?  Yes  No

If yes, please give beginning and end dates of incarceration: \_\_\_\_\_

27. Do you have any children (natural or adopted), who are or were under the age of 18 when you became disabled, that are not living with you?

Yes  No

If you answered yes, please list their name(s) and date(s) of birth:

Name	Date of Birth

28. Please list any outstanding debts that you have:

a. Child support

Amount owed: \_\_\_\_\_

b. Back Taxes (federal)

Amount owed: \_\_\_\_\_

c. Social Security Overpayment from a prior claim

Amount overpaid that has not been paid back: \_\_\_\_\_

29. Please provide the name, address and telephone number of someone who doesn't live with you, but will always be able to find you:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

Telephone: \_\_\_\_\_

Relationship: \_\_\_\_\_

30. Please provide any additional information that you consider important: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

31. Did you need help completing this questionnaire?  Yes  No

If yes, who helped you, and what help did they provide? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_