

**§167 Form: Claimant Questionnaire**

NAME:	TELEPHONE:
ADDRESS:	SSN:
	DATE OF BIRTH: AGE:

- Are you a U.S. Citizen? ☐ Yes ☐ No
- On what date did you apply for social security disability and/or SSI benefits? \_\_\_\_\_
- In your application for benefits, what date did you state as the date you became unable to work? \_\_\_\_\_

LIST YOUR HEALTH CONDITIONS	WHEN DID EACH CONDITION <i>FIRST</i> BOTHER YOU? ( <b>APPROXIMATE DATE</b> )

- When did you stop working? \_\_\_\_\_
- Why did you stop working? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_
- Why can't you work now? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**WORK HISTORY:**

8. Please provide your work history for **15 years** before you became unable to work. Approximate dates are acceptable.

***Start with your most recent job and then the next most recent job, etc.***

DATES WORKED (MONTH & YEAR) FROM: TO:		NAME <b>AND ADDRESS</b> OF EMPLOYER	NAME OF JOB & JOB DUTIES	HOURS PER DAY	REASON FOR LEAVING	HOURS PER WEEK	RATE OF PAY
				Sitting: ____ Standing: ____ Walking: ____			
				Sitting: ____ Standing: ____ Walking: ____			
				Sitting: ____ Standing: ____ Walking: ____			
				Sitting: ____ Standing: ____ Walking: ____			
				Sitting: ____ Standing: ____ Walking: ____			

				Walking: _____			
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*(Use additional sheets of paper, if necessary.)*

**USUAL WORK:**

9. Which work do you consider to be your usual work? \_\_\_\_\_

**MOST RECENT JOB:**

10. For your *most recent job* in addition to the information provided on page 2, please answer the following:

a. What was the *greatest* weight you had to lift or carry on this job? \_\_\_\_\_ pounds

1) How many times per day would you lift or carry this much? \_\_\_\_\_ times per day

2) What object(s) weighed this much? \_\_\_\_\_

b. What was the *average* weight you had to lift or carry on this job? \_\_\_\_\_ pounds

1) How many times per day would you lift or carry this much? \_\_\_\_\_ times per day

2) What object(s) weighed this much? \_\_\_\_\_

c. Did you use machines, tools or equipment of any kind? ☐ Yes ☐ No

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

\_\_\_\_\_

d. Did you use technical knowledge or skills? ☐ Yes ☐ No

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

\_\_\_\_\_

e. Did you do any writing, complete reports, or perform similar duties? ☐ Yes ☐ No

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

\_\_\_\_\_

f. Did you have supervisory responsibilities? ☐ Yes ☐ No

If yes, how many people did you supervise? \_\_\_\_\_

- 
- 
- 

11. Which job listed on page two would be the easiest for you to do now, considering your medical problems? (Do not describe any job that lasted less than three months.)

a. Supervisor's name: \_\_\_\_\_

- b. In an average workday, how many hours were spent: Sitting: \_\_\_\_\_  
Standing: \_\_\_\_\_  
Walking: \_\_\_\_\_
- c. What was the *greatest* weight you had to lift or carry on this job? \_\_\_\_\_ pounds
- 1) How many times per day would you lift or carry this much? \_\_\_\_\_ times per day
- 2) What object(s) weighed this much? \_\_\_\_\_
- d. What was the *average* weight you had to lift or carry on this job? \_\_\_\_\_ pounds
- 1) How many times per day would you lift or carry this much? \_\_\_\_\_ times per day
- 2) What object(s) weighed this much? \_\_\_\_\_

12. Have you ever had a desk or sit down job? ☐ Yes ☐ No When? \_\_\_\_\_

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

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**Office Skills:**

_____	<input type="checkbox"/> Filing	<input type="checkbox"/> Typing / w.p.m.: _____
	<input type="checkbox"/> Office Machines	<input type="checkbox"/> Computers
	<input type="checkbox"/> Dictation	<input type="checkbox"/> Bookkeeping
	<input type="checkbox"/> Other _____	

**RECENT WORK:**

14. Are you working now? ☐ Yes ☐ No
- a. If so, where? \_\_\_\_\_
- b. Earnings per month (gross) \$ \_\_\_\_\_
15. Have you worked anywhere since you became disabled? ☐ Yes ☐ No
- When? \_\_\_\_\_ What job? \_\_\_\_\_
- Where? \_\_\_\_\_ Why did job end? \_\_\_\_\_
16. Have you applied for unemployment compensation (UC) since the date you became unable to work? ☐ Yes ☐ No
- If yes, did you receive UC benefits? ☐ Yes ☐ No
- If yes, what dates did you receive UC benefits? \_\_\_\_\_
- If no, why didn't you receive UC benefits? \_\_\_\_\_
17. Have you ever lost or quit a job because of your limitations? ☐ Yes ☐ No
- Explain yes answer: \_\_\_\_\_
18. Have you applied for any jobs since the date you became unable to work? ☐ Yes ☐ No
- If yes, what job(s) did you apply for? \_\_\_\_\_
19. Are there any of your previous jobs that you think you might be able to do? ☐ Yes ☐ No
- If yes, which one(s)? \_\_\_\_\_

**EDUCATION:**

20. What was the highest grade you completed in school? \_\_\_\_\_
- a. When did you last go to school? \_\_\_\_\_
- b. Name of last school: \_\_\_\_\_ City & State: \_\_\_\_\_
- c. Did you repeat any grades? ☐ Yes ☐ No If yes, which one(s)? \_\_\_\_\_
- d. Were you in special classes? ☐ Yes ☐ No If yes, describe? \_\_\_\_\_

- e. If you left school before completing high school,
- 1) Did you get a GED? ☐ Yes ☐ No When? \_\_\_\_\_
  - 2) What was the reason for leaving school? \_\_\_\_\_
- f. How well do you read?
- ☐ Above Average      ☐ Below Average  
☐ Average      ☐ Illiterate/unable to read English
- If below average or illiterate,
- 1) Are you able to read a menu or list? ☐ Yes ☐ No
  - 2) Are you able to read simple instructions? ☐ Yes ☐ No
  - 3) Has your reading been tested? If so, where? \_\_\_\_\_
- g. Are you able to do the following mathematics? (Check all that you can do.)
- ☐ Make Change      ☐ Decimals/Fractions  
☐ Add and Subtract      ☐ Higher Mathematics  
☐ Multiply and Divide
- h. Were you an ☐ A ☐ B ☐ C ☐ D student in high school?

**VOCATIONAL TRAINING:**

21. For any vocational training you have had in your life, please identify the school, the type of training, dates attended and whether you completed the program: \_\_\_\_\_

a. Have you ever been evaluated by the state vocational rehabilitation agency?

☐ Yes ☐ No If no, why not? \_\_\_\_\_

b. If yes, please complete the following:

VOC. REHABILITATION COUNSELOR'S NAME	ADDRESS	DATES

**MILITARY:**

22. Were you ever in the military? ☐ Yes ☐ No

a. Branch: \_\_\_\_\_ When? \_\_\_\_\_ Highest Rank: \_\_\_\_\_

b. Nature of discharge: \_\_\_\_\_

c. Describe any special training: \_\_\_\_\_

\_\_\_\_\_

**VETERANS DISABILITY:**

23. Have you ever applied for VA disability? ☐ Yes ☐ No

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

b. What was the percentage rating? \_\_\_\_\_ What was the date of the rating? \_\_\_\_\_

c. When did benefits begin? \_\_\_\_\_

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

\_\_\_\_\_

e. 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): \_\_\_\_\_

\_\_\_\_\_

**MEDICAL INFORMATION:**

24. Current Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_

a. How much is your usual weight? \_\_\_\_\_

b. When was the last time you weighed your usual weight? \_\_\_\_\_

25. Do you smoke? ☐ Yes ☐ No If yes, how much? \_\_\_\_\_

26. Have you ever been treated by a psychiatrist or psychologist? ☐ Yes ☐ No

If yes, give details including dates, reasons for treatment, and nature of treatment: \_\_\_\_\_

\_\_\_\_\_

27. Have you ever had any problems with alcohol or drug abuse? ☐ Yes ☐ No

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

28. Have you ever been treated for alcohol or drug abuse? ☐ Yes ☐ No

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

b. When did you recover from alcohol/ drug abuse? \_\_\_\_\_



### **CURRENT MEDICAL PROBLEMS**

29. Since the date you became disabled, have you been getting better or worse?

☐ Better      ☐ Worse      ☐ Same

30. Will you ever get well enough to work again? ☐ Yes ☐ No If yes, when? \_\_\_\_\_

31. Has any doctor told you not to work? ☐ Yes ☐ No If yes, who? \_\_\_\_\_ When? \_\_\_\_\_

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

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

b. Which doctor(s) told you this? \_\_\_\_\_ When? \_\_\_\_\_

33. Do you have a handicapped-parking permit? ☐ Yes ☐ No

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

34. Which doctor knows you best? \_\_\_\_\_

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

Shortness of breath	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Alcohol abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Coughing up blood	<input type="checkbox"/> Yes	<input type="checkbox"/> No	High blood pressure	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Hot/cold flashes	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dizziness	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Excessive sweating	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Swelling of feet/ankles	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Heart palpitations	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Blackouts	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Diarrhea	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Fatigue	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Controlling your urine	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Difficulty sleeping	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Vision	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent weight loss	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Drug abuse	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Recent weight gain	<input type="checkbox"/> Yes	<input type="checkbox"/> No

36. If you answered Yes to Drug Abuse in the above question, please explain:

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37. Do you drink any alcohol? ☐ Yes ☐ No

If yes, please answer the following questions:

a. What sort of alcoholic beverage do you usually drink? \_\_\_\_\_

b. How much alcohol do you drink in a typical week? \_\_\_\_\_

- c. During the past month, was there any single day in which you had five or more drinks of beer, wine or liquor? ☐ Yes  
☐ No
- d. During the past six months, have you thought you should cut down on your drinking of alcohol? ☐ Yes ☐ No
- e. During the past six months, has anyone complained about your drinking? ☐ Yes ☐ No
- f. During the past six months, have you felt guilty or upset about your drinking? ☐ Yes ☐ No
- g. As a result of alcohol use, have you ever lost a job? ☐ Yes ☐ No
- h. As a result of alcohol use, have you ever lost a friend? ☐ Yes ☐ No

**PAIN:**

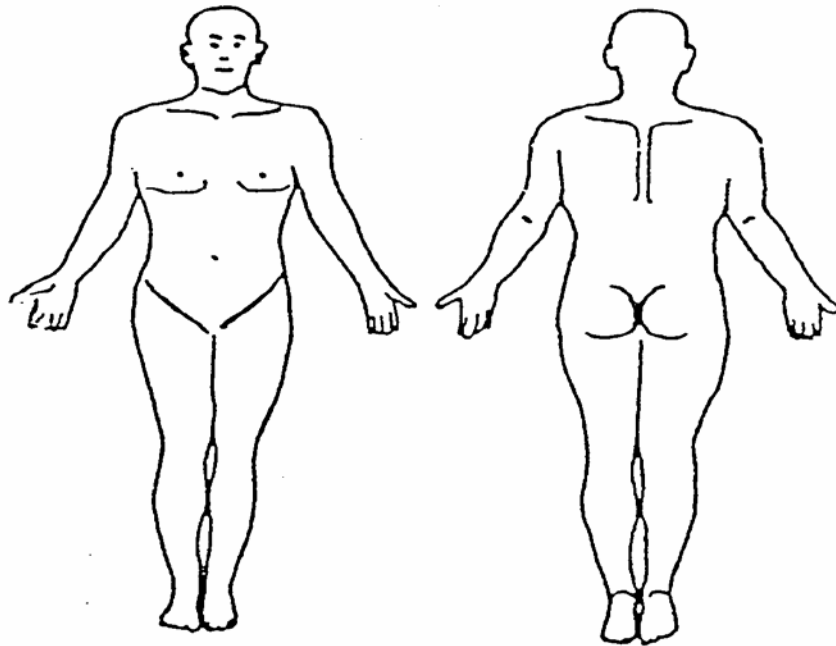
38. If your disability involves physical pain, answer the following: (If physical pain is not your problem, go on to question #39.)

- a. Approximate date pain began: \_\_\_\_\_
- b. What event caused the pain (e.g., accident, disease, surgery, unknown)? \_\_\_\_\_  
\_\_\_\_\_
- c. What does your pain feel like? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- d. What reasons have your doctors given for your pain? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_
- e. Does pain ☐ lessen or ☐ increase when you push on the painful spots?
- f. Are any of the following associated with your pain? Check those that apply:

<input type="checkbox"/>	Numbness	<input type="checkbox"/>	Tingling (pins and needles)	<input type="checkbox"/>	Weakness
<input type="checkbox"/>	Increased sweating	<input type="checkbox"/>	Muscle spasm	<input type="checkbox"/>	Skin discoloration
<input type="checkbox"/>	Nausea	<input type="checkbox"/>	Loss of sleep	<input type="checkbox"/>	Crying spells
<input type="checkbox"/>	Loss of concentration	<input type="checkbox"/>	Depression	<input type="checkbox"/>	Agitation



- g. Location of pain: Please shade in areas of pain.  
**BE AS SPECIFIC AS POSSIBLE.**



- h. Is pain: ☐ Constant? ☐ Often? ☐ Occasional?
- i. How many hours per day do you have pain? \_\_\_\_\_
- j. If you do not have pain every day, estimate how many hours of pain per week, or days per week or month: \_\_\_\_\_
- k. 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"/>
Sitting with legs elevated	<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"/>

l. What else increases your pain? \_\_\_\_\_

\_\_\_\_\_

m. Below is a list of treatments you may have used to relieve pain. For each of these, indicate whether you have tried and, if you tried it, the degree it helped.

Treatment	Have you tried?		Rate Helpfulness 0 = No Help; 10 = Excellent Relief										
Heat	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Massage	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Whirlpool	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Traction	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Prescribed Exercise	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Bed rest	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
TENS (electrical stimulation)	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Biofeedback	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Trigger Point Injections	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Nerve Blocks	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Acupuncture	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Chiropractic Treatments	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Cranial Sacral Therapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Behavior Modification	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Counseling/ Psychotherapy	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Herbs, Vitamins, Supplements, etc.	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10
Pain Clinic/ Pain Program	Yes <input type="checkbox"/>	No <input type="checkbox"/>	0	1	2	3	4	5	6	7	8	9	10

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

\_\_\_\_\_

\_\_\_\_\_



E. Rate how **frequently** you experience pain:

0	1	2	3	4	5	6	7	8	9	10
Rarely										All the time

## II. Activity Limitation or Interference

A. How much does your pain interfere with your ability to **walk one block**?

0	1	2	3	4	5	6	7	8	9	10
Does not restrict ability to walk										Pain makes it impossible for me to walk

B. How much does your pain prevent you from **lifting 10 pounds** (a bag of groceries)?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere at all with lifting 10 pounds										Impossible to lift 10 pounds

C. How much does your pain interfere with your ability to **sit for ½ hour**?

0	1	2	3	4	5	6	7	8	9	10
Does not restrict ability to sit for ½ hour										Impossible to sit for ½ hour

D. How much does your pain interfere with your ability to **stand for ½ hour**?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere at all with standing for ½ hour										Unable to stand at all

E. How much does your pain interfere with your ability to **get enough sleep**?

0	1	2	3	4	5	6	7	8	9	10
Does not prevent me from sleeping										Impossible to sleep

F. How much does your pain interfere with your ability to **participate in social activities**?

0	1	2	3	4	5	6	7	8	9	10
Does not interfere with social activities										Completely interferes with social activities

G. How much does your pain interfere with your ability **to travel up to 1 hour by car?**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere with ability to travel 1 hour by car									Completely unable to travel 1 hour by car	

H. In general, how much does your pain interfere with your **daily activities?**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere with my daily activities									Completely interferes with my daily activities	

I. How much do you **limit your activities to prevent your pain from getting worse?**

0	1	2	3	4	5	6	7	8	9	10
Does not limit activities									Completely limits activities	

J. How much does your pain interfere with your **relationship with your family/ significant others?**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere with relationships									Completely interferes with relationships	

K. How much does your pain interfere with your ability to do **jobs around your home?**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere at all									Completely unable to do any job around home	

L. How much does pain interfere with your ability to **bathe without help from someone else?**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere at all									My pain makes it impossible to shower or bathe without help	

M. How much does your pain interfere with your ability to **write or type?**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere at all									My pain makes it impossible to write or type	

N. How much does your pain interfere with your ability to **dress yourself?**

0	1	2	3	4	5	6	7	8	9	10
Does not interfere at all									My pain makes it impossible to dress myself	



O. How much does your pain interfere with your ability to **concentrate**?

0	1	2	3	4	5	6	7	8	9	10
Never										All the time

**III. Effect of Pain on Mood**

A. Rate your overall mood during the past week.

0	1	2	3	4	5	6	7	8	9	10
Extremely high/ good										Extremely low/ bad

B. During the past week, how **anxious or worried** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10
Not at all anxious/ worried										Extremely anxious/ worried

C. During the past week, how **depressed** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10
Not at all depressed										Extremely depressed

D. During the past week, how **irritable** have you been because of your pain?

0	1	2	3	4	5	6	7	8	9	10
Not at all irritable										Extremely irritable

E. In general, how anxious/ worried are you about performing activities because they **might make your pain/ symptoms worse**?

0	1	2	3	4	5	6	7	8	9	10
Not at all anxious/ worried										Extremely anxious/ worried

**MEDICATIONS:**

39. For each **prescription drug** you are *presently* taking, please complete the following:

NAME OF MEDICATION AND DOSAGE	DAILY AMOUNT TAKEN	FOR WHICH CONDITION	NAME OF PRESCRIBING DOCTOR	APPROX. DATE STARTED	IDENTIFY SIDE EFFECTS YOU ARE HAVING FROM THIS DRUG

40. For each **non-prescription drug** you are taking, complete the following:

NAME OF MEDICATION AND DOSAGE	HOW MUCH DO YOU TAKE PER DAY	FOR WHICH CONDITION

41. For each doctor the **Social Security Administration** sent you to for examination concerning your disability, please complete the following:

NAME AND ADDRESS OF DOCTOR	DOCTOR'S SPECIALTY	APPROX. DATE OF EXAM.	LENGTH OF EXAM (MINUTES)	DESCRIBE THE EXAMINATION AND ANYTHING THE DOCTOR TOLD YOU ABOUT YOUR CONDITION

**DAILY ACTIVITIES:**

42. a. What is the amount of your current income? \$\_\_\_ per month.
- b. What is the source of your current income? \_\_\_\_\_
43. a. Where do you currently live?
- ☐ apartment      ☐ duplex      ☐ single family home
- ☐ condominium      ☐ trailer      ☐ rooming house
- b. Do you own or rent?      ☐ own      ☐ rent

44. a. Please identify all of your children who are now under age 18 or who were under age 18 at the time you became disabled. Please list children even if they do not live with you. For each child who does not live with you, please tell us who the child lives with. Please include each child's date of birth and Social Security Number (SSN).

CHILD'S NAME & SSN	AGE	DATE OF BIRTH	LIVES WITH

- b. Please give the names and ages of people other than your minor children living with you and indicate their relationship to you (e.g., step-son, adult daughter, sister, friend, etc.):

NAME	RELATIONSHIP	AGE	DATE OF BIRTH

45. What are the names of the two people with whom you spend the most time?

a. \_\_\_\_\_ b. \_\_\_\_\_

46. At present, how much time do you spend *each day*:

	HOURS PER DAY
Lying down or reclining	
Sitting upright	
Standing/Walking	
<b>TOTAL HOURS PER DAY:</b>	<b>24</b>

47. a. How well do you sleep? ☐ good ☐ fair ☐ poor

Explain fair or poor answer: \_\_\_\_\_

b. Do you elevate the head of your bed or sleep on extra pillows? ☐ Yes ☐ No

If yes, how high is the head of the bed elevated or how many pillows do you use?

48. a. Indicate if you use any of the following assistive devices:

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Regular cane     | <input type="checkbox"/> Special mattress | <input type="checkbox"/> High toilet seat |
| <input type="checkbox"/> Four-footed cane | <input type="checkbox"/> Hospital bed     | <input type="checkbox"/> Grabber          |
| <input type="checkbox"/> Walker           | <input type="checkbox"/> Shower bar       | <input type="checkbox"/> Sock tube        |
| <input type="checkbox"/> Wheel chair      | <input type="checkbox"/> Shower chair     | <input type="checkbox"/> Lift chair       |

b. Please describe any other assistive devices you use or any home modifications you have done to accommodate your disability:

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

	SEVERAL TIMES A DAY	DAILY	WEEKLY	MONTHLY	NEVER	EXAMPLES - NEED HELP, DO A POOR JOB
Drive						
Cook						
Wash Dishes						

	SEVERAL TIMES A DAY	DAILY	WEEKLY	MONTHLY	NEVER	EXAMPLES - NEED HELP, DO A POOR JOB
Straighten up house						
Dust						
Vacuum						
Mop Floor						
Do laundry						
Clean bathroom						
Make bed						
Change bed sheets						
Yard work						
Gardening						
Shovel snow						
Fix things						
Grocery Shop						
Pay bills, handle finances						
Watch children						
Groom self						
Participate in organizations						
Attend religious services						
Play cards /games						
Attend sports Events						
Hobbies (name)						
Visit relatives						
Visit friends						
Talk to neighbors						

	SEVERAL TIMES A DAY	DAILY	WEEKLY	MONTHLY	NEVER	EXAMPLES - NEED HELP, DO A POOR JOB
Go out to eat or to movies						
Use public transportation						
Exercise						
Watch TV or listen to radio	Number of Hours per day:					
Read	Number of Hours per day:					
Talk on phone	Number of Hours per day:					
Sleep/stay in bed	Number of Hours per day:					
Sleep/lie on couch	Number of Hours per day:					

50. **ONGOING ASSISTANCE:** Does anyone have to help you to do things around the house on a regular basis? Who? What do they do?

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51. **PHYSICAL LIMITATIONS:**

**NOTE:** If your disability is psychiatric and you have no physical limitations, it is not necessary to complete question 52. Go on to question 53 on page

25.

- a. **SITTING:**

What best describes your ability to sit?

<input type="checkbox"/>	I have no problem sitting.
<input type="checkbox"/>	I can sit with some difficulty.
<input type="checkbox"/>	I can sit with great difficulty.
<input type="checkbox"/>	I cannot sit at all.

If you have trouble sitting:

Does it make a difference what kind of chair you sit on?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
What kind of chair is best for you?		
Do you elevate your legs while sitting?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Where do you have pain or discomfort when you sit too long?		
What do you do to relieve that pain or discomfort?		

*List examples of activities you have trouble performing while sitting:*

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- 1) What is your best estimate of how long you can sit **continuously in one stretch** in a work chair (*not* a recliner) before you must get up and move around or lie down?

Hours/minutes:

- 2) If you were sitting on and off throughout a workday, how many hours **total out of an 8-hour workday** in a regular work setting can you sit?

Hours:

**a. STANDING:**

What best describes your ability to stand?

<input type="checkbox"/>	I have no problem standing.
<input type="checkbox"/>	I can stand with some difficulty.
<input type="checkbox"/>	I can stand with great difficulty.
<input type="checkbox"/>	I cannot stand at all.

If you have trouble standing:

Where do you have pain or discomfort when you stand too long?
What do you do to relieve that pain or discomfort?

*List examples of activities you have trouble performing while standing:*

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- 1) What is your best estimate of how long you can stand **continuously in one stretch** without sitting down or walking around?



Hours/minutes:

- 2) If you were standing on and off throughout a workday, how many hours **total out of out of an 8-hour workday** in a regular work setting can you stand?

Hours:

**a. WALKING:**

What best describes your ability to walk?

<input type="checkbox"/>	I have no problem walking.
<input type="checkbox"/>	I can walk with some difficulty.
<input type="checkbox"/>	I can walk with great difficulty.
<input type="checkbox"/>	I cannot walk at all.

If you have trouble walking:

Do you ever use a cane or other device to help you walk?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Where do you have pain or discomfort when you walk too long?		
What do you do to relieve that pain or discomfort?		

*List examples of activities you have trouble performing while walking:*

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- 1) What is your best estimate of how far you can walk **continuously in one stretch** without stopping to rest?

Blocks: \_\_\_\_\_

- 2) How many hours **total out of an 8-hour workday** in a regular work setting can you walk?

Hours: \_\_\_\_\_

**a. LIFTING AND CARRYING:**

What best describes your ability to lift and carry?

<input type="checkbox"/>	I have no problem lifting and carrying.
<input type="checkbox"/>	I can lift and carry with some difficulty.
<input type="checkbox"/>	I can lift and carry with great difficulty.
<input type="checkbox"/>	I cannot lift and carry at all.



If you have trouble lifting and carrying:

What is the heaviest thing that you encounter in your everyday life, which you can still lift or carry (for example, gallon of milk, 8-pack of soda, a bag of groceries, basket of laundry, small children or grandchildren)?	
What happens when you try to lift or carry too much?	

*List examples of things you encounter in your daily life that you can no longer lift or carry:*

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What is your best estimate of the maximum weight you can lift or carry in a regular work situation

- 1) if you had to lift or carry only ***rarely or once in a while?*** \_\_\_\_\_ pounds
- 2) if you had to lift or carry up to ***one-third of the workday?*** \_\_\_\_\_ pounds
- 3) if you had to do it ***from one-third to two-thirds of the workday?*** \_\_\_\_\_ pounds

**e. LEGS AND FEET:**

Do you have any trouble using your legs or feet?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any trouble using your legs and feet to drive a car?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

*Describe the difficulty.*

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**f. ARMS AND HANDS:**

Are you left or right handed?	<input type="checkbox"/> Left	<input type="checkbox"/> Right
Do you have any problems using your hands or arms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do the problems occur with repetitive use of your hands or arms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can you make a fist with each hand?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can you touch each finger to the thumb on each hand?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do your hands shake?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any trouble with your hands being numb or having pins and needles?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any trouble with dropping things?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you lost strength in your hands or arms?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Can you reach above your head (for example, to put things away in kitchen cupboards)?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems writing a letter?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any difficulty playing cards?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

List examples of activities you have difficulty performing with your hands:

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**g. OTHER EXERTIONAL LIMITATIONS:**

Do you have trouble doing any of the following things?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
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If **yes**, complete the following:

	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"/>

**h. ENVIRONMENTAL RESTRICTIONS:** Are there any restrictions on your activities, or problems, which you encounter, having to do with any of the following situations? Describe the problem:

- 1) Unprotected heights: \_\_\_\_\_
- 2) Being around moving machinery: \_\_\_\_\_
- 3) Exposure to marked changes in temperature or humidity: \_\_\_\_\_
- 4) Exposure to dust, fumes or gases: \_\_\_\_\_

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

Depression	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Dealing with the public	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Anxiety attacks	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Relating to other people	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Memory	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Maintaining attention	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Dealing with stress	<input type="checkbox"/> Yes	<input type="checkbox"/> No	Loss of concentration	<input type="checkbox"/> Yes	<input type="checkbox"/> No

53. **GOOD DAYS AND BAD DAYS:**

a. Do you have good days and bad days? ☐ Yes ☐ No

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

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

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

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d. What is a good day like? \_\_\_\_\_

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

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f. What is a bad day like? \_\_\_\_\_

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**OTHER:**

54. Are the medical providers listed on your denial letters a complete listing of those needed to get a full understanding of your disability? ☐ Yes ☐ No

If no, what other medical providers should be contacted? \_\_\_\_\_

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55. What are the name, address and telephone number of someone who doesn't live with you but will always be able to find you?

<b>Name:</b>	
<b>Address:</b>	
<b>Telephone:</b>	
<b>Relationship:</b>	

56. Have you ever been convicted of a felony? ☐ Yes ☐ No

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

57. Are you on probation or parole right now? ☐ Yes ☐ No

If Yes, please provide the following:

Name of probation/ parole officer: \_\_\_\_\_

Probation/ parole officer address: \_\_\_\_\_

\_\_\_\_\_

Probation/ parole officer telephone: \_\_\_\_\_

58. Please provide the following (if you have them):

a. Your cell phone number: \_\_\_\_\_

b. Your fax number: \_\_\_\_\_

c. Your Email address: \_\_\_\_\_

59. Other information you consider important: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

60. Did you need help to complete this questionnaire? ☐ Yes ☐ No

If yes, who helped you? \_\_\_\_\_

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

Date: \_\_\_\_\_

**THIS IS VERY IMPORTANT**

***DOCTORS, ETC.:***

1. For each doctor, chiropractor, psychologist, psychological counselor, etc. 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, ETC.	DATE OF FIRST VISIT (APPROX.)	DATE OF LAST VISIT (APPROX.)	APPROX. HOW MANY VISITS TOTAL?	WHICH CONDITION WAS TREATED	DESCRIBE ANY RESTRICTION OF ACTIVITIES IMPOSED OR WHAT YOU WERE TOLD ABOUT YOUR CONDITION

***(CONTINUED ON NEXT PAGE)***

**DOCTORS, ETC.** - Continued

NAME AND ADDRESS OF DOCTOR, ETC.	DATE OF FIRST VISIT (APPROX.)	DATE OF LAST VISIT (APPROX.)	APPROX. HOW MANY VISITS TOTAL?	WHICH CONDITION WAS TREATED	DESCRIBE ANY RESTRICTION OF ACTIVITIES IMPOSED OR WHAT YOU WERE TOLD ABOUT YOUR CONDITION

**(PLEASE USE ADDITIONAL PAPER, IF NECESSARY)**



**HOSPITALIZATIONS:**

2. For each *hospitalization* (where you stayed at least one night), please complete the following chart.

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

NAME AND ADDRESS OF HOSPITAL	APPROX. DATES	WHY WERE YOU HOSPITALIZED	DESCRIBE THE TREATMENT YOU RECEIVED	NAMES OF DOCTORS WHO TREATED YOU

***(PLEASE USE ADDITIONAL PAPER, IF NECESSARY)***

3. 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:

***List your most recent visit first and work your way back to about 5 years before you became unable to work.***

NAME AND ADDRESS OF HOSPITAL, CENTER OR CLINIC	APPROX. DATE	DESCRIBE THE TREATMENT OR DIAGNOSTIC TESTS	NAMES OF DOCTORS OR THERAPISTS

***(PLEASE USE ADDITIONAL PAPER, IF NECESSARY)***