§175 Interview Form

Name: ______________________________ __ Mr. __ Ms. Date: ______________

Address: ______________________________ Time:________Rep: ______ Asst. ____

______________________________ SSN: ________________________

Telephone: ______________________________ DOB: ____________

Message #: ______________________________ Age: ____________

__ Married __ Single __ Widow __ Divorced __ Separated

Other names used during relevant time period: ________________________________

Total number of children:	Number of children under 18 or older but still in high school, at anytime after onset date:	Number of stepchildren under 18* who reside with claimant:
Spouse:	Name:	Years Married:
[Parent's name in child's case]	SSN:* *SSI disabled couple and Widow(er) cases only	Date of Death [Widow(er)]:

Referred By: __________________ Type of Claim:_____________________ __ Initial __ Term __ Other

ALJ:__________________________ Fee: __ Petition __ Agreement __Two-Tier __ W/holding waived

ALJ Address: ________________________ Stage of Claim: _________________________

Local Office Address:____________________ Awaiting:_______________________________________

Hearing		*Cessation/Termination Cases*	
Date:	Time:	Date Disability Ceased:	
VE:		Continuing Benefits: __ Yes __ No	
ME:		Date Last Check:	Amount of Check:

Hearing Preparation Appointment:	Date:	Time:

Prior Applications: __ Yes __ No Dates and Results: ______________________________________

Identify reopening earlier application as issue on Analysis form.

Application/Termination	Reconsideration	Hearing Request
Application Date:	Recon. Request Date:	__ Not yet filed
Denial/Term. Date:	Recon. Denial Date:	Date filed:
Rationale:	Rationale:	Timely: __ Yes __ No
		Why not?

Identify any problem with timeliness of appeal as issue on Analysis form.

PRESENT SYMPTOMS

	SYMPTOM 1	SYMPTOM 2	SYMPTOM 3	SYMPTOM 4
Location:				
Description: (consider describing occasional radiation of pain as a separate symptom)				
Frequency:				
Duration:				
What starts it?				
What aggravates it?				
Intensity at its worst 1 - 10:				
Usual intensity 1 - 10:				
Intensity at its best 1 - 10:				
What makes it better?				
Effectiveness of medication:				
Side effects of medication:				

Rank symptoms on Analysis form.

How *often* do you have any of the following?

Nausea:		Crying spells:	
Fainting:		Headaches:	
Dizziness:		Spasms:	
Bladder control problems:		Cramps:	
Seizures:		Diarrhea:	
Dates of most recent seizures:			

At what pharmacies have you purchased seizure medication in the past year?__________________________

Can you ask your pharmacist(s) to provide a summary of all seizure medication purchased in the past year?

Have you had any of the following tests recently?

TEST	WHERE DONE	APPROX. DATE
Treadmill Stress Test		
Other Heart Tests Identify:		
EMG/Electro diagnostic Studies		
X-ray/CAT Scan Part of Body:		
MRI Part of Body:		
Myelogram:		
Breathing Tests:		
MMPI		
Other:		

FAMILY, HOUSING AND INCOME:

List all children who were under 18 (or under 19 and still in high school or disabled adult children) at any time after the alleged onset date. Identify custodian.

CHILDREN'S NAMES	RELATIONSHIP	DOB	CUSTODIAN

How many people are in your household? _______________

Monthly Income:	**CLAIMANT**	**SPOUSE**
*Employment after onset from to		
*Unemployment compensation after onset from to		
Welfare: Type: TANF GA		
Food Stamps:		
V.A. benefits: Type: Service connected; non-service connected:		
Worker's Compensation after onset from to		
Loans:		
Investments:		
Disability Insurance: (*Enter name and address of LTD carrier on Analysis form.)*		
Pension Benefits (company):		
SSI (Especially Spouse SSI):		
Social Security Disability/ Retirement:		
TOTAL: Family:		

**Identify these as issues on Analysis form.*

Place of birth: ___________________________ Resided in state __ all life/since _______________________________

__ A U.S. citizen. __ Not a U.S. citizen. Resided in U.S. __ all life/since: _______________________

Immigration Status: ____

DAILY ACTIVITIES:

What floor is bedroom on?__________________________ Trouble with stairs? __ Yes __ No

Which is worse, going up stairs or down? __ Up __ Down,

Rise: ____________ a.m. Retire: ____________ p.m.

Do you nap during the day? __ Yes __ No Where do you nap? _______________________________

How many times? ____________________________________ How long? _____________________________________

Do you have rest periods during the day? __ Yes __ No

Where do you rest? ____________________

How many times? ____________________ How long? ____________________

Do you have a particular chair, couch, etc. that is most comfortable? Describe: ____________________

Summary of typical day: ____________________

____

____

Do you attend religious services? __ Yes __ No How often? ____________________

Are you active in any groups, clubs, etc.? __ Yes __ No Describe: ____________________

____

Are you involved in any volunteer work? __ Yes __ No Describe: ____________________

____

Present hobbies:____________________

____

Former hobbies that you can no longer do: ____________________

____

PHYSICAL ASSESSMENT

Rank *sitting, standing, walking* from easiest to hardest: Easiest: ____________________

Hardest:____________________

Assuming that everyone, even the most disabled people, can do some sort of work, describe what you think

you can do:____________________

If pain is involved, how *often* is your experience of pain severe enough to interfere with attention and concentration?

__ Never __ Seldom __ Often __ Frequently __ Constantly

To what *degree* does it interfere?

__ Would prevent performance of simplest tasks.

__ Would only prevent performance of more complicated tasks such as those involved in semi-skilled work.

__ Would only prevent performance of very complicated tasks such as those involved in skilled work.

ENVIRONMENTAL RESTRICTIONS:	NO RESTRICTION	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Extreme cold				
Extreme heat				
Wetness				
High humidity				
Noise				
Chemicals				
Solvents/cleaners				
Soldering fluxes				
Cigarette smoke				
Perfumes				
Fumes, odors, dusts, gases				
List other irritants or allergens:				
Hazards (machinery, heights, etc.)				

Describe how these environmental factors impair activities and identify hazards to be avoided.

____

MENTAL RESIDUAL FUNCTIONAL CAPACITY

	I. MENTAL ABILITIES AND APTITUDES NEEDED TO DO UNSKILLED WORK	**Unlimited or Very Good**	**Limited but satis-factory**	**Seriously limited, but not precluded**	**Unable to meet competitive standards**	**No useful ability to function**
	Remember work-like procedures					
	Understand and remember very short and simple instructions					
	Carry out very short and simple instructions					
	Maintain attention for two hour segment					
	Maintain regular attendance and be punctual within customary, usually strict tolerances					
	Sustain an ordinary routine without special supervision					
	Work in coordination with or proximity to others without being unduly distracted					
	Make simple work-related decisions					

	Complete a normal workday and workweek without interruptions from psychologically based symptoms					
	Perform at a consistent pace without an unreasonable number and length of rest periods					
	Ask simple questions or request assistance					
	Accept instructions and respond appropriately to criticism from supervisors					
	Get along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes					
	Respond appropriately to changes in a routine work setting					
	Deal with normal work stress					
	Be aware of normal hazards and take appropriate precautions					

	II. MENTAL ABILITIES AND APTITUDES NEEDED TO DO SEMISKILLED AND SKILLED WORK	**Unlimited or Very Good**	**Limited but satis-factory**	**Seriously limited, but not precluded**	**Unable to meet competitive standards**	**No useful ability to function**
	Understand and remember detailed instructions					
	Carry out detailed instructions					
	Set realistic goals or make plans independently of others					
	Deal with stress of semiskilled and skilled work					

Explain limitations falling in the three most limited categories (identified by **bold type)**:

____

____

____

____

____

If stress tolerance is an issue, what demands of work do you find stressful?

__ speed

__ precision

__ complexity

__ deadlines

__ working within a schedule

__ being criticized by supervisors

__ simply knowing that work is supervised

__ getting to work regularly

__ remaining at work for a full day

__ fear of failure at work

__ making decisions

__ exercising independent judgment

__ completing tasks

__ working with other people

__ dealing with the public (strangers)

__ dealing with supervisors

__ monotony of routine

__ little latitude for decision-making

__ lack of collaboration on the job

__ no opportunity for learning new things

__ underutilization of skills

__ lack of meaningfulness of work

MEETING THE MENTAL LISTING - THE B CRITERIA

	FUNCTIONAL LIMITATION				
	Restriction of activities of daily living	None Mild __	Moderate __	Marked __	Extreme __
	Difficulties in maintaining social functioning	None Mild __	Moderate __	Marked __	Extreme __
	Deficiencies of concentration, persistence or pace	None Mild __	Moderate __	Marked __	Extreme __
	Repeated episodes of decompensation within 12 month period, each of at least two weeks duration*	None __	One or Two __	Three __	Four or More __

* If within one year client had more than three episodes of decompensation of shorter duration than two weeks or less frequent episodes of decompensation of longer duration than two weeks, state the dates of each episode of decompensation:

____

If at Listing level (2 Marked or 1 Extreme limitation), indicate which Listing is met and describe why you think client meets Listing:

LITIGATION AND OTHER DETAILS (Include Attorney's Name, Address & Telephone)

WORKER'S COMPENSATION: ____

____

INSURANCE AND PENSION: ____

____

OTHER CLAIMS FOR BENEFITS: ____

____

POTENTIAL WITNESSES

NAME	TELEPHONE NUMBER	AREA OF TESTIMONY

ATTORNEY'S NOTES

Best indications of inability to work:* ____

____

Potential problems with case* ____

____

**Summarize issues on Analysis form.*

OBSERVATIONS

CHECK ITEM TO INDICATE DIFFICULTY WAS OBSERVED

__ Reading	__ Hearing	__ Using Hands	__ Walking
__ Writing	__ Speaking	__ Breathing	__ Sitting
__ Answering	__ Understanding	__ Seeing	__ Rising

Describe difficulty with checked item(s):____

____

____

Describe posture:

____

Describe unusual appearance, behavior or observed difficulty not noted elsewhere:

____

____

Assistive devices:

____

GENERAL APPEARANCE

Skin:		Deformities:	

Body build:		Hand calluses:	