BASIC QUESTIONNAIRE

NAME: _____ TELEPHONE: _____

ADDRESS: _____ SSN: _____

_____ DATE OF BIRTH: _____ AGE: _____

MOTHER'S MAIDEN NAME: _____ PLACE OF BIRTH:

FOR MR. RATCLIFF TO BE ABLE TO HELP YOU OBTAIN SOCIAL SECURITY DISABILITY BENEFITS, IT IS VERY IMPORTANT THAT YOU ANSWER ALL OF THESE QUESTIONS AS TRUTHFULLY AND AS COMPLETELY AS YOU CAN. MR. RATCLIFF WILL GO OVER THEM WITH YOU WHEN HE MEETS WITH YOU, AND IF YOU ARE UNABLE TO ANSWER A QUESTION, YOU CAN EXPLAIN WHY NOT TO HIM AT THAT TIME.

1. Are you a U.S. citizen? ☐ Yes ☐ No If yes, go to question 2. If no, what is your country of origin? _____

   If no, what is your immigration status? _____

2. ***EDUCATION:*** What was the highest grade you **completed** in school? _____

   a. When did you last go to school? _____ Where? _____

   b. Circle whether you were an A B C D F student in school.

   c. Did you repeat any grades? ☐ Yes ☐ No If yes, which ones? _____

   d. Were you in special classes? ☐ Yes ☐ No If yes, describe? _____

   e. Did you leave school before completing high school? ☐ Yes ☐ No

   If yes, what was the reason for leaving school? _____

   If yes, did you get a GED? ☐ Yes ☐ No When? _____

   e. What arithmetic or mathematics are you able to do (please check all that you can do)?

   ☐ Make Change ☐ Decimals/Fractions ☐ Other _____
   ☐ Add and Subtract ☐ Algebra
   ☐ Multiply and Divide ☐ Geometry

   f. Are you able to read English at least some? ☐ Yes ☐ No

   If yes, how well do you read English? ☐ Above Average ☐ Average ☐ Below Average

   If your reading is below average, are you able to read a menu or list? ☐ Yes ☐ No

   If your reading is below average, are you able to read simple instructions? ☐ Yes ☐ No

   Has your reading been tested? ☐ Yes ☐ No If yes, when and where? _____

   Do you have at least an average ability to read a language other than English? ☐ Yes ☐ No

   If yes, what language or languages? _____

3. ***VOCATIONAL EVALUATION OR TRAINING:***

A. Have you ever been evaluated by a state vocational rehabilitation agency? ☐ Yes ☐ No

If no, go to B. If yes, please provide the information asked in the following table.

VOC. REHABILITATION COUNSELOR OR AGENCY NAME	WHERE?	WHEN

B. Have you ever had any vocational training? ☐ Yes ☐ No If no, go to the first question in the next section.

If yes, please provide the information asked in the following table and answer the question after the table.

	WHAT WERE YOU TRAINED TO DO?	WHERE WERE YOU TRAINED?	WHEN?

Did you complete all of the training you listed in the table? ☐ Yes ☐ No If yes, go to the next section.

If no, put a check mark in the shaded box on the left of the line where you listed the training.

4. ***MILITARY*****:** Were you ever in the military? ☐ Yes ☐ No If no, please skip to question 5.

What branch?: _____ What was your highest rank? _____

How long did you serve? _____

When did you start? _____ When were you discharged? _____

What was the nature of your discharge: _____

Did you receive any special training in the military? ☐ Yes ☐ No If yes, what was the training?

_____

5. ***VETERAN'S BENEFITS, INCLUDING TREATMENT***: If you receive no VA benefits, skip to question 6.

Do you receive medical treatment from the VA? ☐ Yes ☐ No

If yes, do you get all of your treatment from the VA? ☐ Yes ☐ No

Have you ever applied for VA disability benefits? ☐ Yes ☐ No

If yes, do you receive VA benefits? ☐ Yes ☐ No If no, why not? _____

If you receive VA benefits, please check whether they are ☐ service connected ☐ non-service connected

What percentage is your disability rating? _____% What was the date of the rating decision? _____

Do you have a copy of the rating decision? ☐ Yes ☐ No If yes, please provide us with a copy.

When did your benefits begin? _____ How much are the benefits? _____

Do you have a VA disability benefit claim pending now? ☐ Yes ☐ No If yes, please give us the

name, address and phone number of your representative (if you have one): _____

What are the medical problems that your VA claim or rating is based on? _____

_____

6. ***EMPLOYMENT:***

Have you worked anywhere since you filed for SS benefits this time? ☐ Yes ☐ No If no, go on to question numbered 7.

If yes, have you worked more than one place since then? ☐ Yes ☐ No If yes, how many places? _____

If only one, what is that employer's name? _____ What job do or did you do? _____

Are you still working there? ☐ Yes ☐ No If no, when did you stop? _____ When did you start? _____

How many hours per week do (did) you work? _____ How much do (did) you make? $ _____ per _____

7. What was your last job before you applied for benefits this time? _____

How long had you worked there? _____ On what date did you stop work on that job? _____

If you do not know the exact date, about when did you stop working? _____

8. Why did you stop working your last job (check all that apply)? ☐ I quit ☐ I was laid off ☐ I was fired

☐ The job ended ☐ I was unable physically to perform the job ☐ I was unable mentally[1] to perform the job

☐ Other reasons: _____

[1] A mental impairment can be a mental illness such as depression or generalized anxiety disorder (and there are many others) which has been diagnosed by a doctor. But it doesn't have to be. It can also be because you have problems remembering, understanding or carrying out instructions. Or you may have problems making job related decisions or dealing with changes in the work setting or unusual work situations. And you may have difficulty getting along with supervisors or coworkers. All of these would be mental.

9. What thing or things did your last job require you to do which you are no longer able to do? _____

_____

_____

_____

10. Did you attempt unsuccessfully to work anywhere since your last job before you applied for benefits? ☐ Yes ☐ No

If yes, have you attempted to work more than one job? ☐ Yes ☐ No If yes, how many more? _____

Why were you unable to get or keep another job? _____

_____

If you have attempted to get or work at **many** jobs since your last one, **please use an extra sheet of paper to list them and to explain why you were not able to get or keep them even if it is always the same.**

11. Have you applied for any jobs since your last job before you applied for benefits? ☐ Yes ☐ No

a. If yes, what jobs did you apply for? _____

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

12. Have you received unemployment compensation (UC) benefits since you became unable to work? ☐ Yes ☐ No

If yes, about when did you start receiving UC benefits? _____ When did they end? _____

If you do not know, contact the Office of Employment Security for a printout showing what benefits you received.

13. Have you received workers' compensation benefits since you became unable to work? ☐ Yes ☐ No

If yes, what date did you start receiving WC benefits? _____ When did they end? _____

14. Have you ever lost or quit a job because of your limitations? ☐ Yes ☐ No Explain a yes answer:

_____

15. Have you ever had a desk or sit down job? ☐ Yes ☐ No If yes, when? _____

What was the job? _____

16. Have you ever had an office job? ☐ Yes ☐ No If yes, when? _____

What was the job? _____

17. Do you have any of these office skills (check all that apply)? ☐ Filing ☐ Typing / w.p.m.: _____

☐ Office Machines ☐ Computers ☐ Dictation ☐ Bookkeeping ☐ Other _____

18. ***WORK HISTORY***: PLEASE PROVIDE YOUR WORK HISTORY BACK TO 1993 OR AS FAR BACK AS YOUR VERY FIRST JOB. START WITH YOUR LAST FULL TIME JOB AND END WITH YOUR VERY FIRST JOB OR YOUR FIRST JOB IN 1993. APPROXIMATE DATES ARE ACCEPTABLE, BUT BE AS ACCURATE AS POSSIBLE. USE ADDITIONAL SHEETS OF PAPER, IF NECESSARY.

	DATES WORKED FROM:	TO:	EMPLOYER NAME, CITY, AND STATE	NAME OF YOUR JOB OR JOBS	WHAT DID YOU DO MOST?	WHAT PREVENTS YOU FROM RETURNING TO THIS JOB?
1					Sitting: ____ Standing:____ Walking:____	
2					Sitting: ____ Standing:____ Walking:____	
3					Sitting: ____ Standing:____ Walking:____	
4					Sitting: ____ Standing:____ Walking:____	
5					Sitting: ____ Standing:____ Walking:____	
6					Sitting: ____ Standing:____ Walking:____	
7					Sitting: ____ Standing:____ Walking:____	
8					Sitting: ____ Standing:____ Walking:____	
9					Sitting: ____ Standing:____ Walking:____	
10					Sitting: ____ Standing:____ Walking:____	
11					Sitting: ____ Standing:____ Walking:____	
12					Sitting: ____ Standing:____ Walking:____	
13					Sitting: ____ Standing:____ Walking:____	

19. Of the jobs you listed in column 3 of the preceding table which job or jobs do you consider to be your usual work (answer using the numbers in the shaded column on the left)?

_____

20. Are there any of your previous jobs that you think you might be able to do? ☐ Yes ☐ No If yes, which one(s) (use the numbers again)?

_____

21. For your *most recent job* (the last full time job before you applied for benefits) in addition to the information you provided in the top row in the table on page 3, please answer the following:

***NAME OF MOST RECENT PRIOR JOB*:** _____

a. How many pounds was the *heaviest* thing you had to lift or carry on this, most recent job, even if not very often? _____ 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. Think of something you had to lift and carry frequently on this job, even if not very heavy. How much did it weigh? _____ pounds

1) How many times per day would you lift or carry this object? _____ 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, which ones? _____

_____

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

If yes, which ones? _____

_____

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

If yes, what did you do? _____

_____

f. Did you supervise anyone? ☐ Yes ☐ No If yes, how many? _____

g. Before you left this job, did your medical problems require you to make any changes in the hours of work, the way you worked, your job duties, absences, etc.? ☐ Yes ☐ No If so, what were these changes?

_____

_____

22. Even if you can't do it considering your medical problems, which job or jobs listed on page 3 would be the *easiest* for you to do? Do not name any job that lasted less than three months.

NAME OF EASIEST PRIOR JOB: _____

For your easiest job, 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 *most common* 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, which ones? _____

_____

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

If yes, which ones? _____

_____

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

If yes, what did you do? _____

_____

f. Did you supervise anyone? ☐ Yes ☐ No If yes, how many? _____

g. Before you left this job, did your medical problems require you to make any changes in the hours of work, the way you worked, your job duties, absences, etc.? ☐ Yes ☐ No If so, what were these changes?

_____

_____

_____

23. ***YOUR CURRENT LIVING SITUATION:***

What is the amount and source of **you**r current income? _____

. Where do you live? ☐ apartment ☐ duplex ☐ single family home ☐ on the street

☐ trailer ☐ rooming house ☐ other: _____

How many bedrooms are there where you live? _____

Do you own or rent or stay with others? ☐ own ☐ rent ☐ stay with friends or family

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

NAME	RELATIONSHIP	AGE	DATE OF BIRTH

Do any of the persons living with you have an income of any kind? ☐ Yes ☐ No

If yes, please provide the name of the person or persons and his or her or their approximate monthly income.

_____

_____

_____

What are the names and telephone numbers of the two people with whom you spend the most time?

a._____ b. _____

24. ***DAILY ACTIVITIES*:** At present, how much time do you spend *each day* doing things while:

ACTIVITY	HOURS
Asleep	
Awake, but lying down on couch or reclining in recliner	
Sitting upright	
Standing or walking	
TOTAL HOURS PER DAY:	**24**

25. How well do you **usually** sleep? ☐ Good ☐ Fair ☐ Poor

Explain fair or poor answer: _____

_____

What position do you usually sleep in? ☐ On Side ☐ On Stomach ☐ On Back

☐ Other: Describe: _____

Do you elevate the head of your bed? ☐ Yes ☐ No

If yes, how high is the head of the bed elevated? _____

Do you sleep on more than one pillow? ☐ Yes ☐ No

If yes, how many pillows do you use? _____

What kind of mattress do you use (check all that apply)?

☐ Regular Mattress ☐ Egg Crate Mattress

☐ Waterbed ☐ Other special mattress: describe: _____

Is the mattress hard or soft? ☐ Hard ☐ Soft

26. ***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? _____ How many bad? _____

c. What tends to produce good days? _____

_____

d. What is a good day like? _____

_____

_____

e. What tends to produce bad days? _____

_____

f. What is a bad day like? _____

_____

_____

27. **READ THESE INSTRUCTIONS CAREFULLY AND FOLLOW THEM IN ORDER**: **FIRST**, (1) CHECK ALL THE ACTIVITIES YOU NEVER DO. **NEXT**, (2) CHECK THE ONES YOU DO AT LEAST ONCE A DAY. **AFTER THAT** (3) CHECK THE ONES YOU DO AT LEAST ONCE A WEEK. **THEN**, (4) CHECK THE ONES YOU DO AT LEAST ONCE A MONTH. **WHEN YOU FINISH, THERE SHOULD BE ONLY ONE CHECK MARK IN EACH ROW.**

ACTIVITY	1. NEVER	2. DAILY	3. WEEKLY	4. MONTHLY	
Drive					
Cook					
Wash dishes					
Vacuum floor					
Sweep floor					
Mop floor					
Do laundry					
Clean bathroom					
Make bed					
Change sheets					
Yard or garden work					
Grocery shop					
Other shop					
Pay bills					
Watch children					
Watch TV or listen to radio					
Read					
Talk on phone					
Sleep or stay in bed or on couch					
Attend church					
Play table games like cards					
Attend sports events					
Visit relatives, friends, neighbors					
Take the bus					

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

Who and what do they do? _____

_____

_____

29. Have you ever been convicted of a felony? ☐ Yes ☐ No If yes, explain: _____

_____

_____

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

Dealing with the public:	☐ Yes	☐ No	Anxiety attacks:	☐ Yes	☐ No
Relating to other people:	☐ Yes	☐ No	Memory:	☐ Yes	☐ No
Maintaining attention:	☐ Yes	☐ No	Dealing with stress:	☐ Yes	☐ No
Depression:	☐ Yes	☐ No	Loss of concentration:	☐ Yes	☐ No

31. What is 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 numbers: _____

Relationship to you: _____

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

If no, what other medical providers should be contacted? _____

_____

_____

33. Other information you consider important: _____

_____

34. Did you need help to complete this questionnaire? ☐ Yes ☐ No If yes, who helped you? _____

_____

_____

35. It is important for you to date and sign the questionnaire.

Date: _____ _____