QUESTIONNAIRE

NAME:	HOME PHONE:
ADDRESS:	CELL PHONE:
	SSN:
	DATE OF BIRTH:
E-MAIL:	AGE:

1. Are you a U.S. Citizen? ☐ Yes ☐ No

2. On what date did you apply for social security disability and/or SSI benefits? _____

3. In your application for benefits, what date did you state as the date you became unable to work? _____

4.

LIST YOUR HEALTH CONDITIONS	WHEN DID EACH CONDITION *FIRST BOTHER YOU? (**APPROXIMATE DATE**)*

5. When did you stop working? _____

6. Why did you stop working? _____

_____

_____

7. 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 ***AND ADDRESS*** 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: ____			
				Sitting: ____ Standing: ____ Walking: ____			

(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? _____

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.? If so, what were these changes?

_____

_____

_____

EASIEST JOB:

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.)

_____

For your easiest job, please answer the following:

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? _____

SENDENTARY / OFFICE WORK:

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

If yes: When? _____

Where? _____

13. Have you ever had an office job? ☐ Yes ☐ No

If yes: ***Office Skills:***

☐ Filing ☐ Typing / w.p.m.: _____

☐ Office Machines ☐ Computers

☐ Dictation ☐ Bookkeeping

☐ Other _____

RECENT WORK:

14. Are you working now? ☐ Yes ☐ No

If yes, where? _____

Earnings per month (gross): $ _____

15. Have you worked anywhere since you became disabled? ☐ Yes ☐ No

If yes, 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

If yes, 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 yes, describe problem: _____

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

If yes, when and where? _____

a. 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

If yes, please describe the limitations: _____

_____

a. Which doctor(s) told you this? _____

b. 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	☐ Yes	☐ No	Alcohol abuse	☐ Yes	☐ No
Coughing up blood	☐ Yes	☐ No	High blood pressure	☐ Yes	☐ No
Hot/cold flashes	☐ Yes	☐ No	Dizziness	☐ Yes	☐ No
Excessive sweating	☐ Yes	☐ No	Swelling of feet/ankles	☐ Yes	☐ No
Heart palpitations	☐ Yes	☐ No	Blackouts	☐ Yes	☐ No
Diarrhea	☐ Yes	☐ No	Fatigue	☐ Yes	☐ No
Controlling your urine	☐ Yes	☐ No	Difficulty sleeping	☐ Yes	☐ No
Vision	☐ Yes	☐ No	Recent weight loss	☐ Yes	☐ No
Drug abuse	☐ Yes	☐ No	Recent weight gain	☐ Yes	☐ No

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

_____

_____

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? _____

_____

_____

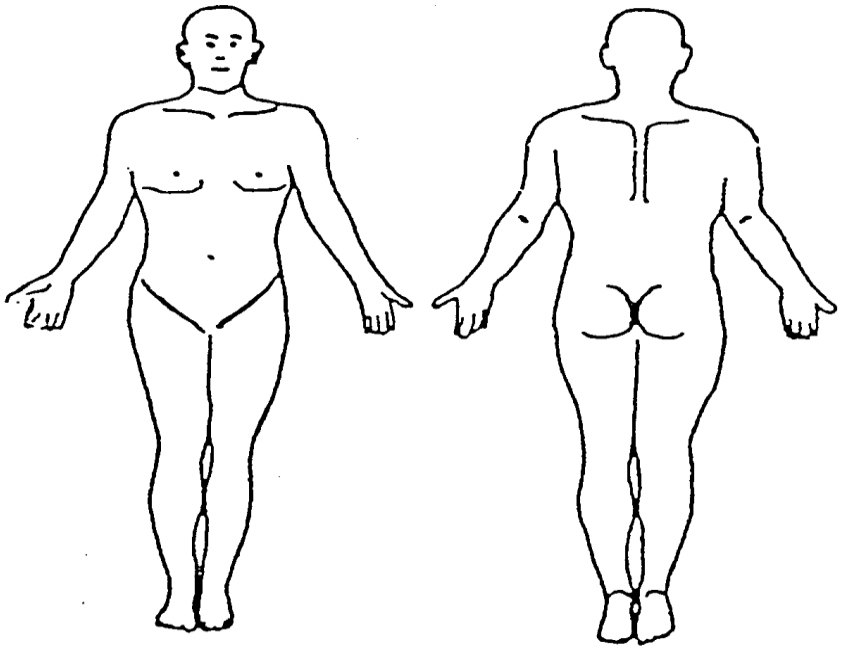
e. Does your pain ☐ lessen or ☐ increase when you push on the painful spots?

f. Are any of the following associated with your pain? Check all that apply.

☐	Numbness	☐	Tingling (pins and needles)	☐	Weakness
☐	Increased sweating	☐	Muscle spasm	☐	Skin discoloration
☐	Nausea	☐	Loss of sleep	☐	Crying spells
☐	Loss of concentration	☐	Depression	☐	Agitation

g. Location of pain: Please shade in areas of pain.

BE AS SPECIFIC AS POSSIBLE.



h. Is your 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	☐	☐	☐
Sitting	☐	☐	☐
Rising from sitting	☐	☐	☐
Sitting with legs elevated	☐	☐	☐
Standing	☐	☐	☐
Walking	☐	☐	☐
Bending	☐	☐	☐
Coughing/ Sneezing	☐	☐	☐

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 that it helped.

Treatment	Have you tried?		Rate Helpfulness 0 = No Help; 10 = Excellent Relief										
Heat	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Massage	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Whirlpool	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Traction	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Prescribed Exercise	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Bed rest	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
TENS (electrical stimulation)	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Biofeedback	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Trigger Point Injections	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Nerve Blocks	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Acupuncture	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10

Treatment	Have you tried?		Rate Helpfulness 0 = No Help; 10 = Excellent Relief										
Chiropractic Treatments	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Cranial Sacral Therapy	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Behavior Modification	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Counseling/ Psychotherapy	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Herbs, Vitamins, Supplements, etc.	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10
Pain Clinic/ Pain Program	Yes ☐	No ☐	0	1	2	3	4	5	6	7	8	9	10

n. What other things relieve your pain? _____

_____

_____

_____

_____

o. Does drinking alcoholic beverages relieve your pain? ☐ Yes ☐ No

p. If you did not have pain, what things would you do that you cannot do now because of the pain? _____

_____

_____

_____

_____

_____

q. **Rating Pain**. Circle the ***one*** number that best describes your pain:

I. Pain Severity

A. Rate how severe your pain is **right now, at this moment** when filling out this questionnaire:

0 1 2 3 4 5 6 7 8 9 10
No pain Most severe pain you can imagine

B. Rate how severe your pain is **at its worst**:

0	1	2	3	4	5	6	7	8	9	10
No pain										Excruciating

C. Rate how severe your pain is **on the average**:

0	1	2	3	4	5	6	7	8	9	10
No pain										Excruciating

D. Rate how much your pain is **aggravated by activity**:

0	1	2	3	4	5	6	7	8	9	10
Activity does not aggravate pain										Excruciating following any activity

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

a. _____ b. _____

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

	HOURS PER DAY
Lying down or reclining	
Sitting upright	
Standing/Walking	
TOTAL HOURS PER DAY:	**24**

46. 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?

_____

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

☐ Regular cane	☐ Special mattress	☐ High toilet seat
☐ Four-footed cane	☐ Hospital bed	☐ Grabber
☐ Walker	☐ Shower bar	☐ Sock tube
☐ Wheel chair	☐ Shower chair	☐ Lift chair

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

_____

_____

48. Please check what you do and how often. If you need help or do a poor job, please indicate.

	SEVERAL TIMES A DAY	DAILY	WEEKLY	MONTHLY	NEVER	EXAMPLES - NEED HELP, DO A POOR JOB
Drive						
Cook						
Wash Dishes						
Straighten up house						
Dust						
Vacuum						
Mop Floor						
Do laundry						
Clean bathroom						
Make bed						
Change bed sheets						

	SEVERAL TIMES A DAY	DAILY	WEEKLY	MONTHLY	NEVER	EXAMPLES - NEED HELP, DO A POOR JOB
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						
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:	

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

_____

_____

_____

_____

50. ***PHYSICAL LIMITATIONS:***

NOTE: If your disability is psychiatric and you have no physical limitations, it is not necessary to complete question 50. Go on to question 51 on page 25.

a. ***SITTING:***

What best describes your ability to sit?

☐	I have no problem sitting.
☐	I can sit with some difficulty.
☐	I can sit with great difficulty.
☐	I cannot sit at all.

If you have trouble sitting:

Does it make a difference what kind of chair you sit on?	☐ Yes	☐ No
What kind of chair is best for you?		
Do you elevate your legs while sitting?	☐ Yes	☐ 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:

_____

_____

_____

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:

b. ***STANDING*:**

What best describes your ability to stand?

☐	I have no problem standing.
☐	I can stand with some difficulty.
☐	I can stand with great difficulty.
☐	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:

_____

_____

_____

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:

c. ***WALKING:***

What best describes your ability to walk?

☐	I have no problem walking.
☐	I can walk with some difficulty.
☐	I can walk with great difficulty.
☐	I cannot walk at all.

If you have trouble walking:

Do you ever use a cane or other device to help you walk?	☐ Yes	☐ 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:

_____

_____

_____

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: _____

d. LIFTING AND CARRYING:

What best describes your ability to lift and carry?

☐	I have no problem lifting and carrying.
☐	I can lift and carry with some difficulty.
☐	I can lift and carry with great difficulty.
☐	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, 12-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:

_____

_____

_____

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

Describe the difficulty.

_____

_____

_____

f. ARMS AND HANDS:

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

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

_____

_____

_____

g. OTHER EXERTIONAL LIMITATIONS:

Do you have trouble doing any of the following things?	☐ Yes	☐ No

*If **yes**, complete the following:*

	CAN'T DO AT ALL	ONCE IS OKAY	A FEW TIMES PER HOUR IS OKAY	REPETITIVELY IS OKAY
Bending:	☐	☐	☐	☐
Twisting:	☐	☐	☐	☐
Squatting:	☐	☐	☐	☐
Climbing stairs:	☐	☐	☐	☐

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: _____

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

Depression	☐ Yes	☐ No	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	Loss of concentration	☐ Yes	☐ No

52. ***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? _____

_____

_____

d. What is a good day like? _____

_____

_____

e. What tends to produce bad days? _____

_____

_____

f. What is a bad day like? _____

_____

_____

OTHER:

53. 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? _____

_____

_____

54. What are 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:	

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

If yes, explain: _____

56. 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: _____

57. Other information you consider important: _____

_____

_____

_____

58. 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	APPROXIMATE 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	APPROXIMATE DATE	DESCRIBE THE TREATMENT OR DIAGNOSTIC TESTS	NAMES OF DOCTORS OR THERAPISTS

(PLEASE USE ADDITIONAL PAPER, IF NECESSARY)