

### Claimant Questionnaire

|          |  |
|----------|--|
| NAME:    | TELEPHONE:                               |
| ADDRESS: | SSN:                                     |
|          | DATE OF BIRTH:                      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? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Marriages:

Are currently married? Y/N

Date of marriage: \_\_\_\_\_

City and state of marriage: \_\_\_\_\_

Spouse's first name: \_\_\_\_\_ Spouse's last name (maiden name): \_\_\_\_\_

Age of Spouse: \_\_\_\_\_

Do you have any prior marriages? Y/N

Did marriage last more than 10 years? Y/N

Date of marriage: \_\_\_\_\_

City and State of marriage: \_\_\_\_\_

Spouse's first name: \_\_\_\_\_ Spouse's last name (maiden name): \_\_\_\_\_

Age of Spouse: \_\_\_\_\_

Date marriage ended: \_\_\_\_\_

City and state where marriage ended: \_\_\_\_\_

What city and state were you born in? \_\_\_\_\_

**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: _____<br>Standing: _____<br>Walking: _____ |                    |                |             |
|                                       |                              |                          | Sitting: _____<br>Standing: _____<br>Walking: _____ |                    |                |             |
|                                       |                              |                          | Sitting: _____<br>Standing: _____<br>Walking: _____ |                    |                |             |
|                                       |                              |                          | Sitting: _____<br>Standing: _____<br>Walking: _____ |                    |                |             |
|                                       |                              |                          | Sitting: _____<br>Standing: _____<br>Walking: _____ |                    |                |             |
|                                       |                              |                          | Sitting: _____<br>Standing: _____<br>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? \_\_\_\_\_

**SEMENTARY / OFFICE WORK:**

12. Have you ever had a desk or sit down job?  Yes  No When? \_\_\_\_\_  
Where? \_\_\_\_\_
13. Have you ever had an office job?  Yes  No

**Office Skills:**

- Filing  Typing / w.p.m.: \_\_\_\_\_  
 Office Machines  Computers  
 Dictation  Bookkeeping  
 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<br>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:

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

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

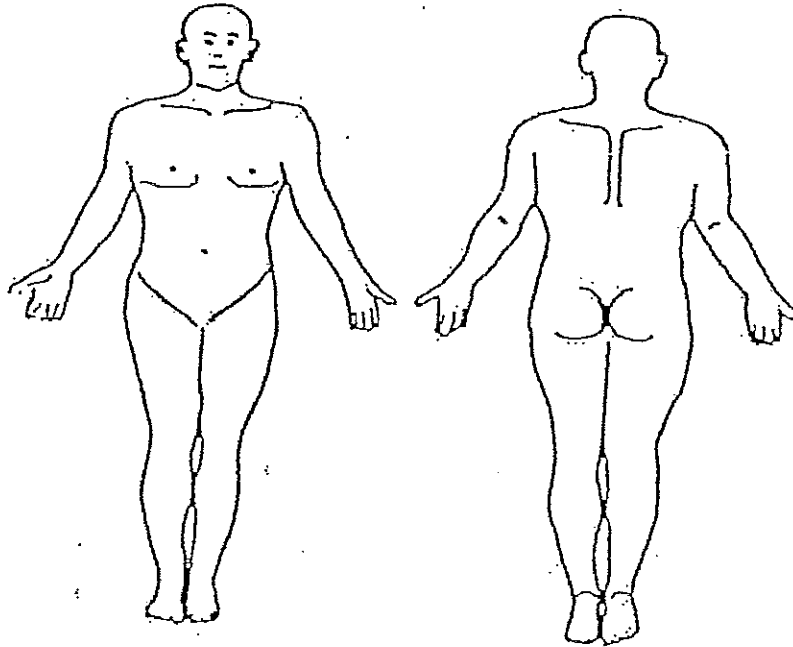
**PAIN:**

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

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

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

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

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

B. 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 Pain makes it impossible  
ability to walk 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 Impossible to lift  
lifting 10 pounds 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 Impossible to sit  
to sit for ½ hour 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      Unable to stand at all  
with standing for ½ hour

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      Impossible  
from sleeping      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      Completely interferes  
with social activities      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      Completely unable to  
to travel 1 hour by car      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      Completely interferes  
with my daily activities      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      Completely limits  
activities      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      Completely interferes  
with relationships      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      Completely unable to  
at all      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



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<br>TIMES A DAY | DAILY | WEEKLY | MONTHLY | NEVER | EXAMPLES - NEED<br>HELP, DO A POOR JOB |
|-------------------------------|------------------------|-------|--------|---------|-------|--|
| Drive                         |                        |       |        |         |       |  |
| Cook                          |                        |       |        |         |       |  |
| Wash Dishes                   |                        |       |        |         |       |  |
| Straighten up<br>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<br>finances |                        |       |        |         |       |  |
| Watch children                |                        |       |        |         |       |  |
| Groom self                    |                        |       |        |         |       |  |

|                              | SEVERAL<br>TIMES A DAY      | DAILY | WEEKLY | MONTHLY | NEVER | EXAMPLES - NEED<br>HELP, DO A POOR JOB |
|------------------------------|-----------------------------|-------|--------|---------|-------|--|
| 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<br>Hours per day: |       |        |         |       |  |
| Read                         | Number of<br>Hours per day: |       |        |         |       |  |
| Talk on phone                | Number of<br>Hours per day: |       |        |         |       |  |
| Sleep/stay in bed            | Number of<br>Hours per day: |       |        |         |       |  |
| Sleep/lie on couch           | Number of<br>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:

---

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:

---

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 |
|--|------------------------------|-----------------------------|

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? \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

f. What is a bad day like?

\_\_\_\_\_

\_\_\_\_\_

**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? \_\_\_\_\_

\_\_\_\_\_

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?

|                      |  |
|----------------------|--|
| <i>Name:</i>         |  |
| <i>Address:</i>      |  |
|                      |  |
| <i>Telephone:</i>    |  |
| <i>Relationship:</i> |  |

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.:**

- 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**

| DATE OF FIRST | DATE OF LAST | APPROX. HOW MANY | DESCRIBE ANY RESTRICTION OF ACTIVITIES IMPOSED OR |
|---------------|--------------|------------------|---|
|               |              |                  |   |



| 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)