DISABILITY QUESTIONNAIRE

Please print, type, or write clearly and answer all items to the best of your ability. If you do not know the answer to any of the questions, enter "unknown." If the question does not apply, enter "N/A." If you need more space to answer any of the questions, please use a separate page and enter the number of the question next to your answer.

1. Full Name _____
2. Telephone Number (including Area Code) _____
3. Email Address _____
4. Address

   _____

   _____

5. Name, telephone number and address of all treating physicians

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   _____
   _____
   _____
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6. Social Security Number

   _____

7. Complete list of all medications

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8. Frequency of visits to your treating physicians

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9. Date of Birth

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10. Education _____

11. Please list the name, address and telephone number of anybody who helped you complete this questionnaire.

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12. Are you married? If so, please state the full name of your husband/wife.

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13. Do you have any children who are under 18 years of age? If so, are any of your children disabled?

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14. Please list every condition which significantly impairs your ability to perform productive activity. "Impair" means to limit your physical or mental ability to perform tasks at work or at home. In your answer, please list your physical and/or mental condition that limits your ability to perform tasks at work or at home, the date that this condition first impaired you and how it impairs you, and the doctors who treat you for this condition.

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15. List all of the names, addresses, telephone numbers, and dates of visits to doctors (physicians, psychologists, psychiatrists, other health care providers etc.) you have seen for all physical and/or mental impairments. For each physician, psychologist, psychiatrist, health care provider listed, please provide their name, address, area of practice, reason they saw and treated you, and the first and late date they saw and treated you.

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16. List the names, addresses, telephone numbers and dates of visits to hospitals where you have been seen for physical and/or mental impairment. Start with the most recent hospital and provide its name, address, telephone number, date you were admitted and discharged, and the reason(s) you were hospitalized.

17. Name and address of all places of employment for the last 15 years

18. Describe the job duties you performed at each place of employment

19. Describe, in detail, your current life activities

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20. Describe, in detail, all of your physical and mental limitations

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21. List the name, address, and telephone number of all individuals who can testify about your disability

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22. Are you receiving any therapy? If so, please describe the type of therapy that you are receiving, the dates that the therapy began and ended, the frequency that you received

the therapy, the purpose of the therapy, and the name and address of the doctor who ordered the therapy.

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23. List all of the tests (e.g. x-ray, MRI, CAT scan, PET scan, etc.) that you have received for your physical and/or mental impairment. For each test, please provide the date it was done, the location that it was rendered, the reason the test was done, and the name and address of the doctor who ordered the test.

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24. What is your height without shoes?

_____
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25. Are you right handed? _____

26. Are you left-handed? _____

27. Do you use both hands the same?

_____
_____

28. Are you currently working?

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29. Can you work all day, five days a week, year round?

_____

30. If no, did your health stop you from working?

_____
_____
_____

31. What month, day, and year did you stop being able to work?

_____

32. Prior to the date you stop working, did your illness/injury cause you to change your job duties, rest while at work, cause you to work fewer hours, get help from other employees, etc?

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_____

33. Please state how many good, fair and bad days you have each month. Consider a month to be 30 continuous days. For purposes of this question, good days mean days when you complete all necessary living and home care activities; fair days mean days when you do a little but fail to complete some necessary living and home care activities; and bad days mean days when you do nothing productive.

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34. Please give examples of how fair or bad days differ from good ones.

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35. Are there days when you do not go out because of your health? If yes, how many days a month does your health keep you from going out? Please explain in detail.

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36. Compared to a year ago, do you function better, worse or the same? Please explain your response.

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37. Do you have serious difficulty taking care of any personal needs, including the following, due to your medical condition? Please circle and describe any that apply, and give additional examples if these don't cover your situation – bathing, shaving, hair care, dressing, eating, sleeping, using the toilet, using stairs, getting to the toilet, holding onto objects, taking medicines on time and in the right dosage, understanding and following instructions, making decisions, doing things on time, finishing things, using the telephone, personal business/finance, helping other, visiting people, shopping, getting to places you want to go, recreation, hobbies keeping well-informed, group activities like church or clubs, and other activities? Describe.

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38. Meals – Do you prepare or serve meals? Yes No

39. If you prepare or serve breakfast, describe what you do and how many days per week do you do it.

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40. If you prepare or serve lunch, describe what you do and how many days per month do you do it.

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41. If you prepare or serve dinner, describe what you do and how many days per week do you do it.

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42. If you prepare or serve breakfast, lunch, or dinner, does anybody help you? If yes, please explain what you do and what they do.

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43. Do you perform home care activities at your residence regularly? If yes, describe the activities you do.

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44. If somebody helps you perform home care duties at your residence, describe what activities others perform for you.

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45. Are there any home care activities which need to be done at your residence but do not get done because of your health? If yes, please describe those activities that do not get done.

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46. In the past, did you do things including recreation that you do not do now because of your health? If yes, please describe what you used to do and why you no longer do them.

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47. Do you have any difficulty sitting, standing, walking, crawling, carrying, lifting, crouching/squatting, pushing/pulling with your hands, pushing/pulling you're your legs, reaching up/out/down, grasping/handling/fingering, bending over, keeping your balance, seeing, hearing, speaking, traveling/driving/using public transportation, understanding, remembering, carrying out instructions, concentrating, finishing what you start, getting along with people who supervise you, getting along with people who annoy you, adjusting to change, functioning in bad environments, like those involving risks, heat/cold/humidity, pollutants, fumes, drafts, irritants, like noise or vibrations and/or working productively all day – every day – year around on a regular and continuing basis? Circle all of those activities that apply to you.

48. Is pain a major factor in the limitation of your activities? If yes, please describe your pain to the best of your ability.

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49. Are you currently employed? If yes, where are you employed? If no, what was the last date you worked and where did you work?

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50. What was the highest grade that you completed in school? What was the last year that you attended school?

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51. Have you had any psychological testing? If yes, please give the date that you were tested, the tests that were given to you, and identify who performed the testing.

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52. Beginning with your most recent job, list every job of the past 15 years. For each job listed, please provide the name of your employer; your job title; the address of your employer; the telephone number of your employer; the date that you began your job; and the date that your job ended.

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53. For each job that you listed in question number 52, please state how many hours a day that you worked; how many days per week did you work; what were your basic duties and responsibilities; and what was your rate of pay.

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54. Did your job end because of your health? If yes, please explain.

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55. For each job that you listed above, please describe the physical and mental activities that were involved in performing your job duties.

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56. For each job listed above, did you use machines, tools or equipment; did you use technical knowledge or skills; did you do any writing, complete reports, or perform similar duties; did you have any supervisory duties or responsibilities; and/or did you serve as a lead worker or crew leader for two or more people? If you answered yes to any of these questions, please describe.

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57. Please describe the typical day on the job for the following: number of hours that involved walking; number of hours that involved standing; number of hours that involved sitting; number of times that involved bending; the kinds of things you lifted regularly; the heaviest things that you lifted; the estimated weight of each item in pounds; the number of times each day you lifted them; the heaviest item that you lifted frequently each day; the number of times each day that you lifted this item; what kinds of things that you carried each day; the heaviest things that you carried each day; the estimated weight of each item that you carried; the number of times each day you carried the item; and the distance that you carried the item each day.

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58. What did you do with the things you lifted or carried?

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59. Identify the most demanding physical and mental tasks of every job that you have performed during the past 15 years.

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60. Name, address, and number of all therapists you are seeing

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61. Name, address, and telephone number of any and all vocational rehabilitation counselor/therapists that you have seen

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62. For all medications that you are taking, list the following

DOSAGE/FREQUENCY

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_____
_____

PRESCRIBED

_____
_____
_____

BY (NAME)

_____
_____
_____

REASON FOR

_____
_____
_____

MEDICATION

_____
_____
_____

SIDE EFFECTS

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_____
_____

DATES FIRST TAKEN/LAST TAKEN

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_____

63. If you are unable to give us information we need, is there someone else who knows about your impairment who can help us get the information we need, and, if necessary, bring you to a consultative examination? If "yes," please provide the following information about this person. Daytime telephone number (including Area Code), Address (Number and Street, City, State and ZIP Code), Relationship (e.g., relative, neighbor, family friend)

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