BASIC QUESTIONNAIRE

NAME: ______________________________ TELEPHONE: ______________________

ADDRESS: ______________________________ SSN: ______________________

______________________________ DATE OF BIRTH: __________ AGE: _________

MOTHER'S MAIDEN NAME: ____________________ PLACE OF BIRTH:

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

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

   If no, what is your immigration status? ______________________________

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

   a. When did you last go to school? ___________ Where? ______________________

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

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

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

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

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

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

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

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

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

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

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

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

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

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

      If yes, what language or languages? ______________________

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

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

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

VOC. REHABILITATION COUNSELOR OR AGENCY NAME	WHERE?	WHEN

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

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

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

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

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

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

What branch?: _________________ What was your highest rank? _______________________________

How long did you serve? ________________

When did you start? ____________ When were you discharged? ______________

What was the nature of your discharge: ____

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

____

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

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

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

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

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

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

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

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

When did your benefits begin? _________________ How much are the benefits? ____________________________

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

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

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

____

6. ***EMPLOYMENT:***

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

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

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

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

How many hours per week do (did) you work? ______________ How much do (did) you make? $ __________ per _______

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

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

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

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

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

☐ Other reasons: ____

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

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

____

____

____

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

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

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

____

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

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

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

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

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

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

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

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

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

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

____

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

What was the job? ____

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

What was the job? ____

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

☐ Office Machines ☐ Computers ☐ Dictation ☐ Bookkeeping ☐ Other ______________________________

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

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

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

____

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

____

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

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

a. How many pounds was the *heaviest* thing you had to lift or carry on this, most recent job, even if not very often? _________ pounds

1) How many times per day would you lift or carry this much? _________ times per day

2) What object(s) weighed this much? ______________________________

b. Think of something you had to lift and carry frequently on this job, even if not very heavy. How much did it weigh? _________ pounds

1) How many times per day would you lift or carry this object? _________ times per day

2) What object(s) weighed this much? ______________________________

c. Did you use machines, tools or equipment of any kind? ☐ Yes ☐ No

If yes, which ones? ____

____

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

If yes, which ones? ____

____

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

If yes, what did you do? ____

____

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

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

____

____

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

NAME OF EASIEST PRIOR JOB: ______________________________

For your easiest job, please answer the following:

a. What was the *greatest* weight you had to lift or carry on this job? ____________pounds

 1) How many times per day would you lift or carry this much? ____________times per day

 2) What object(s) weighed this much? ______________________

b. What was the *most common* weight you had to lift or carry on this job? ____________ pounds

 1) How many times per day would you lift or carry this much? ____________ times per day

 2) What object(s) weighed this much? ______________________

c. Did you use machines, tools or equipment of any kind? ☐ Yes ☐ No

If yes, which ones? ______________________________

____

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

If yes, which ones? ______________________________

____

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

If yes, what did you do? ______________________________

____

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

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

____

____

____

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

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

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

☐ trailer ☐ rooming house ☐ other: ____________

How many bedrooms are there where you live? ______________________________

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

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

NAME	RELATIONSHIP	AGE	DATE OF BIRTH

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

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

____

____

____

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

a.______________________ b. ______________________

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

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

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

Explain fair or poor answer: ____

____

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

☐ Other: Describe: ____

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

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

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

If yes, how many pillows do you use? ________________

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

☐ Regular Mattress ☐ Egg Crate Mattress

☐ Waterbed ☐ Other special mattress: describe: ________________

Is the mattress hard or soft? ☐ Hard ☐ Soft

26. ***GOOD DAYS AND BAD DAYS:***

a. Do you have good days and bad days? ☐ Yes ☐ No

b. Approximately how many days per month are good days? ________ How many bad? ________

c. What tends to produce good days? ____

____

d. What is a good day like? ____

____

____

e. What tends to produce bad days? ____

____

f. What is a bad day like? ____

____

____

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

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

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

Who and what do they do? ____

____

____

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

____

____

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

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

31. What is the name, address and telephone number of **someone who doesn't live with you, but will always be able to find you**?

Name: ______________________________

Address: ______________________________

____

Telephone numbers: ______________________________

Relationship to you: ______________________________

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

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

____

____

33. Other information you consider important: ______________________________

____

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

____

____

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

Date: ______________ ____