SSD/SSI INTERVIEW FORM

Type of Claim: _____ Interview Date: _____

Referred by: _____ By: _____

Name: _____

Address: _____

Telephone: _____ Contact: _____

SSN: _____ D.O.B: _____ Age: _____

Marital Status: _____ Spouse: _____

SSN: _____

Children 19 or younger: _____

_____

_____

Other name(s) used during relevant time period: _____

_____

_____

Local Office: _____

On what date do you feel you became unable to work? _____

Have you worked **at all** since that date? _____YES _____NO

Details: _____

Have you received unemployment compensation at any time since that date? ___YES ___NO

Details: _____

Did you receive workman's compensation or have a claim pending during that period?
_____YES _____NO

Details: _____

Have you received any kind of pension, disability or other regular income since that time?

_____YES _____NO

Details: _____

What prompted you to apply for disability benefits? _____

_____

Why do feel you can't work? _____

_____

Have you ever applied for Disability before? _____YES _____NO

When? _____ Where? _____

What did you apply for, and why? _____

_____

What was the result? _____

Do you have any documents from that claim? _____YES _____NO

Place of Birth: _____ U.S. Citizen? _____YES _____NO

Immigration Status/Relevant Dates: _____

DETAILS, CURRENT APPLICATION

Application	Reconsideration	Hearing Request
App Date:	Recon Req Date:	Not yet filed
Denial Date:	Recon Denial Date:	Date filed:
Rationale:	Rationale:	Timely: Yes No
		Why not?

EDUCATION

When did you last go to school? _____

Where? _____

Highest Grade Level Completed: _____

Degree/Diploma obtained: _____

Reason for leaving school: _____

WORK HISTORY

What kind of work have you done most of your life? _____

Before you stopped working, what adjustments in your work (job duties, hours, attendance, etc.) did you make because of your medical condition? _____

_____

_____

Have you ever lost or quit a job because of your limitations? _____YES _____NO

If yes, please give details _____

_____

_____

SKILLS/APTITUDE

What skills do you still retain from vocational school or learned on the job? *List on Analysis form.*

Reading: (Please circle one)

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

Can you make change and perform simple math like adding, subtracting, multiplying and dividing? _____YES _____NO

Do you have any problems speaking or understanding English? _____YES _____NO

Details: _____

Have you ever been evaluated by the State vocational rehabilitation agency? ___YES ___NO

If no, why not? _____

MEDICAL HISTORY

Just prior to disability onset date were you completely free of symptoms? ___YES ____NO

Since the onset date, have you been getting better or worse? _____ Better _____ Worse

Please give details: _____

_____

Has any doctor told you not to work? _____YES _____NO

If yes, who? _____

PRESENT SYMPTOMS

	Symptom 1	**Symptom 2**	**Symptom 3**	**Symptom 4**
Location				
Description: (consider describing occasional radiation of pain as a separate symptom)				
Frequency				
Duration				
What starts it?				
What aggravates it?				
Intensity at its worst 1 – 10				
Usual intensity 1 – 10				
Intensity at its best 1 – 10				
What makes it better?				
Effectiveness of medication				
Side effects of medication				

Can you get comfortable at night? _____YES _____NO _____Sometimes

Why not? _____

How often do you have any of the following?

Nausea		Crying Spells	
Fainting		Headaches	
Dizziness		Spasms	
Bladder Control Problems		Cramps	
Seizures		Diarrhea	
Dates of most recent seizures			

At what pharmacies have you purchased seizure medication in the past year?

_____

_____

Can you get your pharmacies(s) to provide a summary of all seizure medication purchase in the past year? _____YES _____NO

Height: _____ Weight: _____

Pounds gained or lost in the last year: _____ Usual Weight: _____

Glasses _____YES _____NO Other eye problems: _____

Hearing problem: _____YES _____NO Smoke: _____YES _____NO

How much: _____

Last blood pressure: _____ Allergies: _____

Have you had any of the following which you did not include on the Questionnaire?

Previous Major Illness: _____

Previous Major Operations: _____

Previous Major Injuries: _____

Have you ever been treated by a psychiatrist or psychologist? _____YES _____NO

If yes, give details including dates, reasons for treatment, manifestations of the illness, and nature of treatment. (If lengthy, attach additional sheets).

_____

_____

_____

_____

Have you ever had any problems with drug addiction? _____YES _____NO

If so, describe problem: _____

How much alcohol do you drink per week? _____ drinks

What do you like to drink? _____

Have you ever been treated for alcohol addiction? _____YES _____NO

If yes, when and where: _____

When did you recover from drug/alcohol abuse? _____

Which doctor knows you best? _____

Have you had any of the following tests recently?

TEST	WHERE DONE	APPROXIMATE DATE
Treadmill Stress Test		
Other Heart Tests, identify:		
EMG/Electro diagnostic		
X-ray/CAT Scan Part of Body		
MRI Part of Body		
Myelogram		
Breathing Tests		
MMPI		
Other		

DAILY ACTIVITIES

What floor is Your bedroom on:		Trouble with stairs?	_____YES _____NO
Which is worse, going up stairs or down?	_____ Up _____ Down	Rise _____ a.m.	Retire: _____ p.m.

Do you nap during the day?	_____YES _____NO	Where do you nap?	
How many times?		How long?	
Do you have rest periods during the day?	_____YES _____NO	Where do you rest?	
How many times?		How long?	

Describe a typical day for you, from the time you wake up until the time you go to bed.

_____

_____

_____

_____

Who helps with household chores, shopping, laundry, etc.?

_____

Do you go to church? _____YES _____NO Frequency: _____

Present hobbies: _____

Former hobbies which you can no longer do/why? _____

_____

PHYSICAL ASSESSMENT

Assuming that everyone, even the most disabled person can do some sort of work, describe what you think you can do: _____

_____

1. How many city blocks can you walk without having to stop? _____ blocks.
2. How long can you sit and stand *at one time*?

Sit: 0 5 10 15 20 30 45 (minutes)

1 2 More than 2 (hours)

Stand: 0 5 10 15 20 30 45 (minutes)

1 2 More than 2 (hours)

3. How long can you sit and stand/walk *total in an 8 hour working day* (with normal breaks)?

Sit Stand Walk

_____ less than 2 hours
_____ about 2 hours
_____ about 4 hours
_____ at least 6 hours

4. Do you need to include periods of walking around during an 8 hour working day?

_____YES _____NO

a. Why? _____

b. If yes, approximately how *often* must you walk?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

Times

c. How *long* must you walk each time?

1 5 10 15 20 30 45 60 90

Minutes

5. Do you need a job which permits shifting positions *at will* from sitting, standing or walking?

_____YES _____NO

Why? _____

6. Will you sometimes need to take unscheduled breaks during an 8 hour working day?

_____YES _____NO

If yes,

1) How *often* do you think this will happen? _____
2) How *long* will you have to rest before returning to work? _____

7. With prolonged sitting, do your legs need to be elevated? _____YES _____NO
   If yes, why? _____
   How high? _____

   Percentage of time on sedentary job legs need to be elevated? _____%

8. How many pounds can lift and carry in a competitive work situation?

	Never	**Occasionally**	**Frequently**
Less than 10 lbs			
10 lbs			
20 lbs			
50 lbs			

In an average 8 hour working day, "occasionally" means less than 1/3 of the working day; "frequently" means between 1/3 to 2/3 of the working day.

9. Do you have significant limitations in reaching, handling or fingering?
   _____YES _____NO

   If yes, please indicate the percentage of time during an 8 hour working day on a competitive job that you can use hands/fingers/arms for the following repetitive activities:

	HANDS: Grasp, Turn, Twist objects	**FINGERS:** Fine manipulations	**ARMS:** Reaching (including overhead)

10. Do you have "good days" and "bad days" as far as your pain or other symptoms are concerned? _____YES _____NO

    If yes, please estimate, on the average, how often you are likely to be absent from work as a result of the impairments or treatment:

    _____ Never
    _____ About once a month
    _____ About twice a month
    _____ About three times a month
    _____ About four times a month
    _____ More: _____

11. If pain is involved,
    How *often* is your experience of pain severe enough to interfere with attention and concentration?

    Never Seldom Often Frequently Constantly

To what *degree* does it interfere?

_____ Would prevent performance of simplest tasks.

_____ Would only prevent performance of more complicated tasks such as those involved in semi-skilled work.

_____ Would only prevent performance of very complicated tasks such as those involved in skilled work.

Does the weather or changes in the weather effect your symptoms?

Details: _____

Are you bothered by dust, smoke, fumes or other things found in a work environment?
_____YES _____NO

Details: _____

MENTAL RESIDUAL FUNCTIONAL CAPACITY

I.	MNETAL ABILITIES AND APTITUDE NEEDED TO DO UNKILLED WORK	Unlimited or Very Good	Good	Fair	Poor or None
1.	Remember work-like procedures				
2.	Understand and remember very short and simple instructions				
3.	Carry out very short and simple instructions				
4.	Maintain attention for two hour segments				
5.	Maintain regular attendance and be punctual within customary, usually strict tolerances				
6.	Sustain an ordinary routine without special supervision				
7.	Work in coordination with or proximity to others without being unduly distracted				
8.	Make simple work-related decisions				
9.	Complete a normal workday and workweek without interruptions from psychologically based symptoms				
10.	Perform at a consistent pace without an unreasonable number an length of rest periods				
11.	Ask simple questions or request assistance				
12.	Accept instructions and respond appropriately to criticism from supervisors				
13.	Get along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes				
14.	Respond appropriately to charges in a routine work setting				
15.	Deal with normal work stress				
16.	Be aware of normal hazards and take appropriate precautions				
II.	**MENTAL ABILITIES AND APTITUDES NEED TO DO SEMI-SKILLED AND SKILLED WORK**	**Unlimited or Very Good**	**Good**	**Fair**	**Poor or None**
1.	Understand and remember detailed instructions				
2.	Carry out detailed instructions				
3.	Set realistic goals or make plans independently of others				
4.	Deal with stress of semiskilled and skilled work				

Explain limitations falling into the fair and poor categories: _____

_____

_____

If stress tolerance is an issue, what demands of work do you find stressful?

- ❑ Speed
- ❑ Precision
- ❑ Complexity
- ❑ Deadlines
- ❑ Working within a schedule
- ❑ Making decisions
- ❑ Exercising
- ❑ Independent judgment
- ❑ Working with other people
- ❑ Being criticized by supervisors
- ❑ Simply knowing that work is supervised
- ❑ Dealing with supervisors
- ❑ Getting to work regularly
- ❑ Remaining at work for a full day
- ❑ Fear of failure at work
- ❑ Monotony of routine
- ❑ Little latitude for decision-making
- ❑ Lack of collaboration on the job
- ❑ No opportunity for learning new things
- ❑ Underutilization of skills
- ❑ Lack of meaningfulness of work
- ❑ Completing tasks
- ❑ Dealing with the public (strangers)

CHECK ITEM TO INDICATE DIFFICULTY WAS OBSERVED

□ Writing	□ Speaking	□ Breathing	□ Sitting
□ Answering	□ Understanding	□ Seeing	□ Rising
□ Hearing	□ Using Hands	□ Walking	□ Reading

Describe difficulty with checked item(s): _____

_____

Other observations: _____

_____

_____

_____