

Part of my job is to present your history and current functioning to Disability Adjudication Services. The more information I have, the better the report I will be able to provide.

**Please fill this form out as completely as possible.**

<b>Name:</b>	<input type="checkbox"/> M <input type="checkbox"/> F	<b>DOB:</b>	<b>AGE:</b>
<b>Relational status:</b>	<input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		
<b>Race/Ethnicity:</b>	<b>Number of Children:</b>		
<b>Today's appointment:</b>	<input type="checkbox"/> I drove here <input type="checkbox"/> Someone else drove me <input type="checkbox"/> I took public transportation		
<b>Name of the person who came with you:</b>	<b>Relation to you:</b>		
<b>Do you have a Driver's License?</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No If no, please explain why not:		
<b>Please explain why you are unable to work, and when the problem(s) started:</b>			

**HISTORY**

<b>Early</b>	My mother used drugs, alcohol, or medication while pregnant with me.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
	I was born prematurely.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
	I experienced trauma as a child.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
	I had major medical problems as a child.	<input type="checkbox"/> Yes	<input type="checkbox"/> No	<input type="checkbox"/> I don't know
<b>School</b>	Last grade completed:	GED?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	Did you ever receive special education?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	If yes, starting when?
	What kinds of grades did you make?	<input type="checkbox"/> Mostly A's <input type="checkbox"/> Mostly B's <input type="checkbox"/> Mostly C's <input type="checkbox"/> Mostly failing grades		
	How did you get along with teachers?	<input type="checkbox"/> Well	<input type="checkbox"/> Fairly	<input type="checkbox"/> Poorly
	How did you get along with classmates?	<input type="checkbox"/> Well	<input type="checkbox"/> Fairly	<input type="checkbox"/> Poorly
	Did you get in trouble?	<input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, what for?	
<b>Work</b>	How many jobs have you had?	How long was your longest job?		
	Are you working now?	<input type="checkbox"/> Yes	<input type="checkbox"/> No	
	What kind of work have you done?			
	Why and when did you leave your last job?			
	When did your problems start to affect your work?			
	How did you get along with your supervisors?	<input type="checkbox"/> Well	<input type="checkbox"/> Fairly	<input type="checkbox"/> Poorly
	How did you get along with your coworkers?	<input type="checkbox"/> Well	<input type="checkbox"/> Fairly	<input type="checkbox"/> Poorly
How do you make money now (any odd jobs)?				



Alcohol and Drug Use	Substance used:	Amount used	How often?	If quit, when?	Treatment for this substance?
	Tobacco				
	Alcohol				
	Marijuana				
	Cocaine/crack				
	Heroin				
	Benzos/Sedatives				
	Prescription Pain Pills				
	Methamphetamine				
Other: _____					

  

Legal History	I have been arrested.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	I have spent time in prison.	<input type="checkbox"/> Yes	<input type="checkbox"/> No
	I still have charges/probation/parole pending.	<input type="checkbox"/> Yes	<input type="checkbox"/> No

**CURRENT FUNCTIONING**

<b>In the home</b>	I can bathe and change clothes...	<input type="checkbox"/> by myself	<input type="checkbox"/> only with help	<input type="checkbox"/> never
	I can tidy my room...	<input type="checkbox"/> by myself	<input type="checkbox"/> only with help	<input type="checkbox"/> never
	I can prepare food...	<input type="checkbox"/> by myself	<input type="checkbox"/> only with help	<input type="checkbox"/> never
	I can take my medication...	<input type="checkbox"/> by myself	<input type="checkbox"/> only with help	<input type="checkbox"/> never
<b>Mental tasks</b>	I can use a map or search the internet...	<input type="checkbox"/> by myself	<input type="checkbox"/> only with help	<input type="checkbox"/> never
	I forget where I have put things (keys, wallet, etc.)...	<input type="checkbox"/> hardly ever	<input type="checkbox"/> often	<input type="checkbox"/> all the time
	I forget my middle name...	<input type="checkbox"/> hardly ever	<input type="checkbox"/> often	<input type="checkbox"/> all the time
	I have trouble finishing tasks...	<input type="checkbox"/> hardly ever	<input type="checkbox"/> often	<input type="checkbox"/> all the time
<b>Outside the home</b>	I can shop for groceries...	<input type="checkbox"/> by myself	<input type="checkbox"/> only with help	<input type="checkbox"/> never
	I eat outside the home...	<input type="checkbox"/> 1x per week or more	<input type="checkbox"/> 2-3 x per month	<input type="checkbox"/> 1x per month or less
	I volunteer in my community...	<input type="checkbox"/> 1x per week or more	<input type="checkbox"/> 2-3 x per month	<input type="checkbox"/> 1x per month or less
	I talk to friends (in person or on the phone)	<input type="checkbox"/> 1x per week or more	<input type="checkbox"/> 2-3 x per month	<input type="checkbox"/> 1x per month or less
<b>Daily routine</b>	Please describe your daily routine in as much detail as possible:			

Thank you for completing this questionnaire.