Name of Disability Applicant:
Social Security number:

To be completed with the client:

Living Arrangements:

1. Please describe your current living arrangements (house, apartment, shelter, etc)? _____
2. If homeless, how long have you been homeless? _____
3. Describe what chores you do on a regular basis, and any chores you find difficult to do. _____
4. Does anyone help you take care of chores? If you live with someone else, how are the chores split up? _____
5. Describe what help you need with household chores, including whether of not you need reminders to do chores. _____

Sleeping Habits:

1. How many hours do you usually sleep each night? _____ What time do you get up in the morning? _____ What time do you usually go to bed? _____
2. Do you nap during the day? Yes ☐ No ☐ If so, how many hours do you usually nap? _____
3. How do you sleep? What time of day do you sleep? Do you sleep at irregular hours because you are not able to sleep at night? If you have problems sleeping, please describe problems you have with sleep: _____
4. Do you feel rested after sleeping? Yes ☐ No ☐
5. Do you take any drugs or medication to help you sleep? Yes ☐ No ☐ If so, what do you take? _____
6. When having trouble sleeping, what do you do? _____

Personal Care:

1. Do you need to be reminded to take care of your personal care, such as bathing, shaving, brushing teeth, etc? Yes☐ No☐

2. If yes, how often? _____

3. Do you need help with your personal care, such as bathing, brushing teeth, etc.? Yes☐ No☐

4. Describe what kind of help you need with personal care: _____

Meals/Eating Habits:

1. How many meals do you typically eat each day? What times? What do you eat? If you don't eat regularly, how come? _____

2. Do you need help getting your meals? Yes☐ No☐ If yes, please describe what help you need: _____

3. Do you need to be reminded to eat meals? Yes☐ No☐

4. Do you ever prepare your own meals? Yes☐ No☐ When was the last time you were able to cook? _____

5. If you prepare your own meals, what kind of foods do you know how to cook? How do you prepare them? _____

6. If you prepare your own meals, do you need help preparing the meals? Yes☐ No☐ If yes, please explain what kind of help you need: _____

7. Have your eating habits changed since becoming disabled? Yes☐ No☐ If yes, please describe how your eating habits have changed: _____

8. What is your current weight? _____ lbs What is your current height? _____

9. Has your weight changed since your disability began? Yes☐ No☐ If yes, what is your usual weight? _____

Shopping:

1. If you need to shop for food to last a few days, would you need assistance to shop? Yes☐ No☐

2. If you need assistance shopping, please describe who does with you and what type of assistance he or she provides. _____

3. Are you able to handle your own money or Food Stamps when you buy items at a store? Yes☐ No☐

4. When you have money, are you able to shop independently? Yes☐ No☐

5. Please describe problems you have handling money or shopping: _____

Social Contacts:

1. Do you spend time with other people? Yes☐ No☐

2. How many friends do you have? _____

3. If yes, who do you spend time with and how often do you see them? _____

4. What do you do with other people when spending time with them? (talk, play cards,etc.) _____

5. Please describe any problems you have getting along with other people: _____

6. Do you attend church regularly? ☐ No ☐ Yes, how often? _____

7. How do you usually get around? (Check all that apply)

   ☐Walk ☐Ride bus ☐Drive car ☐Car ride with friend/relative
   ☐Taxi ☐Other:

8. Are you able to take public transportation? Yes☐ No☐

9. If you have problems using public transportation, why? _____

DAILY ACTIVITIES:

1. Please describe your hobbies or activities you enjoy. _____

2. Describe how your disability limits your ability to do hobbies and other activities you enjoy. _____

3. How do you usually spend your days? _____

4. How do you usually spend your evenings? _____

5. Does your routine change on the weekend? If so, how does it change? _____

6. Who does the cleaning? Cooking? Shopping?

7. Describe any problems you have doing these things. _____

8. How is your: Reading Writing Math skills

9. Are you able to read your mail? ☐ Yes ☐ No, describe problems _____

10. Are you able to read the newspaper? ☐ Yes ☐ No, describe problems _____

11. Are you able to make a list? ☐ Yes ☐ No, describe problems _____

12. Are you able to manage your bills without help when you have money? ☐ Yes ☐ No, describe problems _____

Concentration/Memory:

1. Do you have trouble with concentration or remembering things? Yes☐ No☐

If yes, please give examples: _____

2. Do you have any problems following written instructions? Yes☐ No☐

If yes, please give examples: _____

3. Do you have any problems following verbal instructions? Yes☐ No☐

If yes, please give examples: _____

4. Do you have problems finishing things you start to do? Yes☐ No☐

If yes, describe the problems that prevent you from finishing: _____

5. If you watch television, are you able to watch a 1 hour show and follow the story? Yes☐ No☐

6. Are you able to read? Yes☐ No☐

7. Please describe what types of things you read and describe problems you have reading. _____

Treatment:

1. Do you take prescribed medication daily? Yes☐ No☐

2. Who prescribes your medications for you? _____

3. Do you have any side effects from your prescribed medications? ☐ No ☐ Yes, describe the side effects. _____

4. If you are taking any medications for your mental health conditions, do you think they help your symptoms? ☐ No ☐ Yes

5. Do you ever take your medications in a way other than how the doctor has prescribed? ☐ No ☐ Yes, provide details. _____

6. Do you use any prescription medications that were not prescribed for you? ☐ No ☐ Yes, provide details. _____

7. Do you take any non-prescription medication? Yes☐ No☐

8. If yes, please indicate what medications you take and how often: _____

SUBSTANCE ABUSE HISTORY:

1. How often do you use drugs or alcohol? _____

2. Please indicate what types of drugs or alcohol you use: _____

3. If currently using, do you get the shakes when you don't use? ☐ No ☐ Yes
   Do you have blackouts? ☐ No ☐ Yes

4. If so, how often do these things happen? _____

5. Have you ever had drug or alcohol treatment? Yes☐ No☐

6. If yes, please indicate where you received the treatment and the dates you were treated: _____

7. Have you had periods where you did not use drugs or alcohol since your disability began? Yes☐ No☐

8. If yes, please indicate approximate dates of sobriety: _____

9. If you are using alcohol or drugs again, please indicate what prompted the use.
   _____

10. When did you last use drugs or alcohol? _____

11. How many days per week do you drink or use? _____

12. How much do you use? _____

13. What time of day do you start drinking or using? _____

14. Do you smoke cigarettes? ☐ No ☐ Yes, how much? _____

15. Do you drink caffeinated beverages such as coffee, tea, soda or energy drinks? ☐ No ☐ Yes, what and how many per day? _____

PHYSICAL HEALTH HISTORY

1. Do you have physical impairments that limit your ability to work? ☐ No ☐ Yes, what are your physical disabilities? _____

2. Describe how your physical impairments limit your activities. (May need to ask prompting questions such as how much can you lift, how long can you stand before needing to take a break, how long can you sit, can you reach, etc. Questions will depend on what they physical impairment is) _____

Work History:

1. Do you have a history of being fired or quitting jobs due to your disability? Yes☐ No☐

2. How many jobs have you been fired from in the last 5 years? _____

3. Describe problems in past employment that have caused you to quit or be fired. _____

4. If there is a supervisor Social Security may contact to obtain information about problems you had on the job, please provide the date you last worked for the supervisor, the name and address of the company and your supervisor's name and phone number. Providing this information authorizes Social Security to contact this individual. _____

Please provide any other information you think it is important for us to know about how your disability affects your ability to function in your daily activities. Please be as specific as possible and provide details.

_____

Please provide the name, address and phone number of someone who knows you who can give us additional information about your disability and how it affects you. Please note that by providing this information, you are granting permission for Social Security and Job and Family Services to contact this person regarding your disability. (If the

client is currently using drugs or alcohol, please ask for someone who knew them during a period of sobriety):

Claimant Signature _____ Date _____

Name of agency worker who assisted claimant:
Phone Number:

Agency Worker comments: