CLIENT INTERVIEW – SSA/SSI

1. General

Name ____

Address ____
____

Phone _________________ Cell ______________________

Age ______________ DOB ________________________

Place of Birth ______________________________________

Social Security Number _____________________________

E-Mail Address ___________________________________

2. Education

Elementary _______________ Jr. High_________________

High School ______________ College _________________

College Degree ___________ Graduate School ________

Tech. certificates ___________________________________

3. EMPLOYMENT

Employer ____

Address ____

Phone ____

Contact ____

Job Title ____

Job Duties _______________________________________

IF LESS THAN 10 YEARS, PLEASE CONTINUE

NEXT MOST RECENT EMPLOYMENT

Employer ____

Address ____

Phone ____

Contact ____

Job Title ____

Job Duties _______________________________________

EMPLOYMENT

Employer ____

Address ____

Phone ____

Contact ____

Job Title ____

Job Duties _______________________________________

EMPLOYMENT

Employer ____

Address ____

Phone ____

Contact ____

Job Title _______________________________________

Job Duties ______________________________________

4. LIST OF IMPAIRMENTS

Impairment ____________________________________

Date first diagnosed ______________________________

Name of Doctor __________________________________

Address ____

Phone Number ___________________________________

Date last seen ___________________________________

Next Appointment _______________________________

Impairment ________________________________

Date first diagnosed _________________________

Name of Doctor ____________________________

Address ___________________________________

Phone Number _____________________________

Date last seen _____________________________

Next Appointment __________________________

Impairment ________________________________

Date first diagnosed _________________________

Name of Doctor ____________________________

Address ___________________________________

Phone Number _____________________________

Date last seen _____________________________

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Impairment ______________________________________

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Name of Doctor __________________________________

Address ____

Phone Number ___________________________________

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Name of Doctor __________________________________

Address ____

Phone Number ___________________________________

Date last seen ___________________________________

Next Appointment ________________________________

Impairment ___________________________________

Date first diagnosed ____________________________

Name of Doctor ________________________________

Address ______________________________________

Phone Number _________________________________

Date last seen ________________________________

Next Appointment _____________________________

Impairment ___________________________________

Date first diagnosed ____________________________

Name of Doctor ________________________________

Address ______________________________________

Phone Number _________________________________

Date last seen ________________________________

Next Appointment _____________________________

5. CURRENT MEDICATIONS

Name of drug _______________ Prescription YES NO

Dosage (Times/day) _______ Strength ____________

Prescriber name _______________________________

Name of drug ________________ Prescription YES NO

Dosage (Times/day) ________ Strength _____________

Prescriber name _________________________________

Name of drug ________________ Prescription YES NO

Dosage (Times/day) ________ Strength _____________

Prescriber name _________________________________

Name of drug ________________ Prescription YES NO

Dosage (Times/day) ________ Strength _____________

Prescriber name _________________________________

Name of drug ________________ Prescription YES NO

Dosage (Times/day) ________ Strength _____________

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Dosage (Times/day) ________ Strength _____________

Prescriber name _________________________________

Name of drug ________________ Prescription YES NO

Dosage (Times/day) ________ Strength _____________

Prescriber name ________________________________

Name of drug ________________ Prescription YES NO

Dosage (Times/day) ________ Strength _____________

Prescriber name ________________________________

Name of drug ________________ Prescription YES NO

Dosage (Times/day) ________ Strength _____________

Prescriber name ________________________________

Name of drug ________________ Prescription YES NO

Dosage (Times/day) ________ Strength _____________

Prescriber name ________________________________

Name of drug ________________ Prescription YES NO

Dosage (Times/day) ________ Strength _____________

Prescriber name ________________________________

6. PERSONAL INFORMATION

Height _______________ Weight ___________________

Right handed YES NO   Left handed YES NO

Weight Loss last year YES NO How much? __________

Do you use tobacco? YES NO

If yes, describe ____________________________________

Use alcohol? YES NO

If yes, describe ____________________________________

Use illegal drugs? YES NO

If yes, describe ____________________________________

Married YES NO

If yes, name of spouse _____________________________

Household income (VA, Retirement, Other disability):

Source _____________________ Amount/Month ________

Source _____________________ Amount/Month ________

Source _____________________ Amount/Month ________

Source _____________________ Amount/Month ________

Source _____________________ Amount/Month ________

7. ABILITY TO FUNCTION

Check each of the following movements or activities you are unable to do:

Walk __ Stand __ Sit __ Bend __ Stoop __ Reach above head __

Kneel __ Use hand – left __ right __ both __

Lift – 5# __ 10# __ 25# or more __

Carry – 5# __ 10# __ 25# or more __

Are you able to see well? YES NO

Are you able to hear well? YES NO

Do you watch television? YES NO If yes, how many hours/day ___

Are you able to care for your own needs? YES NO If no, who helps you and how often? ____

Do you have any activities outside your home? YES NO If yes, please describe ____

Do you have a Drivers' License? YES NO If yes, are you able to drive a car? YES NO

If no, how do you get around?__________________________________

Do you have problems sleeping? YES NO If yes, why and how long do you normally sleep each night? ____________________

I certify the above information is true and correct to the best of my knowledge.

Date ____________ Signed ____________________________