SSA Psychological Assessment - Intake Interview Form

Date of evaluation: ____________________ Referred by: Social Security Administration

PLEASE LEAVE BLANK: Claimant ID#: ______________________ Bday: ____________

Referral reason (major reasons warranting eval for SSDI) :____

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BACKGROUND / FAMILY DATA

Gender: ☐ Female ☐ Male ☐ Other: ____________

Race: ☐ African-American/Black ☐ Hispanic/Latino(a) ☐ Native American ☐ Asian
☐ Caucasian/White ☐ Pacific Islander ☐ Other: ______________________________

First language: ________________________ Other languages: ____

Housing type: ☐ Apt ☐ House Other: _________________ ☐ Own or ☐ rent?

Currently living w/: ________________________

Any past living situation(s) / location(s) relevant to current situation:

____

How do you currently support yourself financially? ____

Marital Status: (Check all that apply) ☐ Single ☐ Married ☐ Common Law ☐ Separated
☐ Divorced ☐ Committed relationship

Describe romantic relationship history and any relevant factors about those relationships that contribute to how you function emotionally today:

____

____

____

Domestic violence? ____

Emotional support network: ____

Family of origin: (Details on history of relationships with parents/guardians, siblings, extended family)

Parents: ☐ Married (how long? ________) ☐ Never married ☐ Divorced (your age______) ☐ Either deceased? ____________ (When? ________) / ____________ (When? ________)

☐ Raised by bio-mother / bio-father ☐ Raised by two parent household but not both biological parents
☐ Raised by single parent __________ ☐ Raised by parent ______and step-parent _______
☐ Raised by s/o other than parent(s) __________________ ☐ Adopted ☐ Foster care (Ages: _______)

Siblings:

Age	Gender	Any details pertinent to evaluation
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	

Children:

Age	Gender	Any details pertinent to evaluation
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	

Describe upbringing and any relevant factors of family life / relationships that contribute to how you function emotionally today:

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If any of your immediate blood relatives (parents, siblings) suffered the following, indicate who below:
Depression: (their relation to you?)________________________
Anxiety or severe nervousness: ________________________
Mental or nervous breakdown: ________________________

Alcoholism or drug addictions: ____
Mood swings or strange behavior: ______________________________________

MENTAL / PHYSICAL HEALTH

Have you had previous mental health treatment? ☐ Yes ☐ No
From whom? When? ____

Mental health hospitalizations? ____
____

Physical health hospitalizations? ____

Head injuries? ____
Vision problems? Last checked? ____
Hearing probs? Ear infections? ____
Other chronic health conditions? ____
Medications? For what? How much/often? (Please include additional sheet if extensive)
____
____
Medications taken today: ____

Mark an X for any of the following symptoms for which you have experienced in general. Recent is in the last month or so. History refers to throughout your life or for the last several years. **If any significantly impair your ability to work, instead mark with an "SI" to signify significant impairment.**

Recent	*History*	*Symptom*	*Recent*	*History*	*Symptom*
		Depressed mood or frequent crying			Sleep difficulties
		Exhaustion / tiredness			Mourning the loss of something/ someone
		Feeling guilt or shame			Feeling helpless
		Feeling worthless			Feeling hopeless
		Changes in appetite / weight			Sleeping only a few hours a night for several days at a time
		Not wanting to do things you once enjoyed or be social			Decreased need for sleep while feeling well rested
		Suicidal thoughts or behaviors; thoughts of death			Frequent mood swings
		Poor body image			Elevated or manic mood for 1+ wk
		Low self-esteem			Inflated self-esteem (grandiosity)
		Sexual problems			Increased energy

Recent	*History*	*Symptom*	*Recent*	*History*	*Symptom*
		Frequent headaches			Racing thoughts
		Worry, tension, anxiety			Reckless or risk-taking behaviors
		Need for control			Poor judgment
		Excessive fears			Restlessness / irritability
		Nightmares			Increased creativity / productivity
		Avoiding ppl, places, things			Irritability
		Constant awareness of what is around you			Hearing or seeing things or ppl that others tell you are not there
		Compulsive behaviors			Suspicious of others
		Obsessive thoughts or behaviors			Fear of being outside or around others
		Urges to do things perfectly			Feeling like you are not in your own body
		Panic attacks: describe:			Aggressive behaviors, angry outbursts or arguments with others
		Specific phobia:			Restrictive eating
		Trouble concentrating			Binge eating
		Easily distractible			Other disordered eating behaviors

Please describe any symptoms not mentioned here that are important or elaborate on any above: __________

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Substance Use

Drug	Current? Past?	How often? How much?	Age began	Treated?	Problem?
Alcohol					
Marijuana					
Cigarettes					
Other – specify					
Other – specify					

Additional substance information: ____

____

Current thoughts of hurting yourself?	Current plan/ method?	Previous thoughts or attempt(s)?

Current thoughts of hurting s/o else?	Current plan/ method?	Previously violent?

Addtl info - suicide, self-harm, or harm-to-others (e.g., cutting): ______________________________

____

Criminal Hx: Misdemeanors? Felonies? When? For what? ______________________________

____

Trauma hx? Physical Abuse? Sexual Abuse? ______________________________

____

Abuse reported? By whom? To whom? When? ______________________________

____

EDUCATIONAL / DEVELOPMENTAL HISTORY

Birth – Normal? Complications? ______________________

Any delays with: Crawling? Walking? Talking? Reading? Writing? ______________________

____

Previous psychological evaluation(s) with testing? Age? When? Where? ______________________

Diagnosis(es)? ______________________________________

Please describe any current problems with:

	Describe functioning / problem	*How long has it been a problem?*
Memory		
Concentration		
Organization		
Distractibility		
Impulsivity		
Inattention		
Hyperactivity		
School problems		

Grades repeated? ____________________ Why? ____

Graduate HS? _________________ If no, highest grade COMPLETED: __________________ When? __________________

Military service? Branch? When? Other relevant info? ____

Special education classes? ___________________________ Special schools? _________________________

Post-secondary Education Hx:

Date(s)	Institution	Studied	Problems? Accommodations?

Vocational Training Hx:

Date(s)	Institution	Studied	Problems? Accommodations?

EMPLOYMENT HISTORY

Dates	*Length of Employment*	*Employer*	*Duties*	*Why Left?*

FUNCTIONALITY / WORK ASSESSMENT (for adults)

Check if you can independently perform these activities? ☐ hygiene/grooming ☐ bathing ☐ dressing ☐ cooking ☐ cleaning ☐ laundry ☐ shopping ☐ driving ☐ use public transportation ☐ manage own finances

Please answer the following to assess the extent of your impairment related specifically to your capacity to work. It indicates the level of severity of problems you are experiencing which may (or may not) reduce your ability to participate in full or part-time work. Important to note: **the scales refer to the severity of impairment**. (N/A = not assessed or info not provided; None = no problems, OR mild, mod=moderate, severe problems). Please leave last two columns blank.

Functional Impairment	Severity of Impairment						
Ability to seek employment, get or keep a job	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Motivation to work	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Low energy level, stamina to work	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Physical pain:________________________	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Sleep and/or waking problems:	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Motor coordination problems or mobility issues	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Ability to keep regular attendance; punctuality	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Task completion, whether performing tasks alone or in groups	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Work pace, time management	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Ability to understand, remember and carry out simple instructions	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Ability to understand, remember and carry out complex instructions	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Decision-making, planning	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	

Functional Impairment	Severity of Impairment						
Mental / cognitive flexibility	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Ability to sustain an ordinary routine without supervision	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Regulation of emotion	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Stress tolerance or handling other psychological demands; Ability to adapt to challenging situations	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Insight and judgement	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Ability to accept instruction or criticism	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Maintaining and managing interactions with other people, in a contextually and socially appropriate manner (in accordance with social rules and conventions)	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Controlling verbal and physical aggression	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Work in a field other than the one with most experience	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
Transferrable skills to another line of work	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
The ability to perform physical demands of work activities, such as sitting, standing, walking, lifting, carrying, pushing, pulling, or other physical functions (including manipulative or postural functions, such as reaching, handling, stooping, or crouching	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	
The ability to adapt to environmental conditions, such as temperature extremes or fumes	None ☐	Mild ☐	Mod ☐	Severe ☐	N/A ☐	☐ D	

<u>ADDITIONAL NOTES / COMMENTS (Please use additional sheets as necessary.)</u>