center for
VALUED LIVING

Social Security Disability Assessment - Intake Interview Form

PLEASE WRITE LEGIBLY AND BE AS THOROUGH AS POSSIBLE

Name: _____ Date/Time of appt: _____ Bday: _____ Age: _____

NOTE: If the claimant is a child and you are filling this out for them, please answer all relevant questions for the child, not yourself. Put n/a if not relevant to the child.

Applying for SSDI: ☐ First time application ☐ Have applied #___ times before and have been denied ☐ Currently receive SSDI and up for re-evaluation ☐ Used to receive SSDI but lost my benefits and now re-applying / being re-evaluated

SSDI application primarily for: ☐ Physical disability only ☐ Mental disability only ☐ Both

Referral reason (major reasons for applying for SSDI – What are your struggling with that is work impairing? Be specific about the mental and/or physical problems you experience for which you are submitting an SSDI claim only. Please do not include reasons / problems not associated with your claim.

_____

_____

_____

BACKGROUND / FAMILY DATA

Gender: ☐ Female ☐ Male ☐ Other: _____ First language: _____ Other languages: _____

(Check all that apply) Race: ☐ African-American/Black ☐ Hispanic/Latino(a) ☐ Native American ☐ Asian ☐ Caucasian/White ☐ Pacific Islander ☐ Other: _____

Housing type: ☐ Apt ☐ House Other: _____
☐ I own ☐ I pay rent ☐ Others own or rent and I am financially support by others
Currently living w/ whom?: (include # of ppl and relationship)_____

How do you currently support yourself financially? ☐ Family help _____ ☐ Savings ☐ Food Stamps ☐ AND ☐ Disability (SSI/SSDI) ☐ Child support ☐ Alimony ☐ TANF ☐ Current job ☐ Spouse or partner's income ☐ Medicare or Medicaid for health ☐ Other: _____

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

Who supports you emotionally: _____

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

_____

_____

_____

_____

_____

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

YOUR Parents: ☐ Married (how long? _____) ☐ Never married ☐ Divorced (your age_____)
☐ Either deceased? _____ (When? _____) / _____ (When? _____)

☐ Raised by bio-mother AND bio-father ☐ Raised by single parent (which one?)_____
☐ Raised by bio-parent (which one?) _____and step-parent ☐ Raised by someone other than bio parent(s) _____ ☐ Adopted ☐ Foster care (Ages: _____)

Siblings: DO NOT PUT THEIR NAMES PLEASE (# sisters _____, # brothers _____) Bio? Half? Step?

Age	Gender	Any relevant details (how is your relationship, where they are etc.)
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	

Your Children: DO NOT PUT THEIR NAMES PLEASE

Age	Gender	Any relevant details (how is your relationship, where they are etc.)
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	
	☐ M ☐ F	

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

_____

_____

_____

_____

Do your immediate blood relatives (parents, siblings, children) suffer from mental health problems? If yes, describe: _____

MENTAL / PHYSICAL HEALTH

Have you had previous mental health treatment? ☐ Yes ☐ No

From whom? When? _____

Mental health hospitalizations? _____

Physical health hospitalizations? _____

Vision problems? Describe. _____

Hearing probs? Hearing aids? _____

TBI? Stroke? Other neurocognitive probs? _____

Other chronic health conditions? _____

_____

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

Prev. mental health Diagnos(es)? _____

Medications? For what? How much/often? (Please include additional sheet if extensive)

_____

_____

_____

Mark the review column with an X for any of the following diagnoses/symptoms that we should review in more depth. *Also mark with an "WI" to signify if it is work-impairing.*

Review X	*WI?*	*Diagnosis or symptom*	*Review X*	*WI?*	*Diagnosis or symptom*
		Depression			Bipolar mania
		Anxiety			Eating disorder
		Trauma / PTSD			Autism / autistic spectrum
		Panic			Sleep problems
		Obsessive-compulsive thoughts or behaviors			ADHD, inattention and/or hyperactivity
		Substance abuse			Concentration problems
		Traumatic brain injury			Short-term memory problems
		Social anxiety			Long-term memory problems
		Physical or verbal aggression towards others			Visual or auditory hallucinations or delusions (psychosis)
		Motor coordination or mobility problems			Other neurological problem
		Physical pain (describe)			Agoraphobia (fear of being in public)
		Stroke			Other:

Substance Use

Drug	Current? Past?	How often? How much?	Age began	Treated?	Problem?
Alcohol					

Marijuana					
Cigarettes					
Other – specify					

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?

Criminal History: Misdemeanors? Felonies? When? For what? _____
_____

Trauma history? Physical Abuse? Sexual Abuse? Reported? _____
_____

EDUCATIONAL / DEVELOPMENTAL HISTORY
Normal Birth? Complications? _____
Any delays with: Crawling? Walking? Talking? Reading? Writing? _____
_____

Grades repeated? _____ Why? _____

Graduate HS? _____ If no, highest grade COMPLETED: _____ GED? _____

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

Special education classes? For what/when? _____
☐ Pull-Out/Push-In services? ☐ Inclusion/Integrated Classroom? ☐ Self-contained class?

College Education:

Date(s)	Institution	Studied	Completed program?	If no, why not?

Vocational / Trade Training Hx:

Date(s)	Institution	Studied	Completed program?	If no, why not?

EMPLOYMENT HISTORY

When were you most recently employed? _____ Why stopped? _____

What type of work have you done historically and in what field(s)? _____

_____

_____

What other field(s) or type of job can you work in and if you cannot, why not? _____

_____

Have you ever been fired or left a job because you did not work well with others? Please describe.

_____

Please include thorough work history:

Dates or Length of Employment (months/years)	*Employer*	*Duties/Type of work performed*	*Why Left?*

Check if you can perform these activities <u>without</u> help? ☐ hygiene/grooming ☐ bathing ☐ dressing ☐ cooking ☐ cleaning ☐ laundry ☐ shopping ☐ driving ☐ using public transportation ☐ managing own finances If you cannot, why not? _____

For below, indicate if you have been <u>medically restricted</u> from performing any of these physical activities:

☐ sitting ☐ standing ☐ walking ☐ lifting ☐ carrying ☐ bending

If not medically restricted by a doctor, explain your difficulties with each:

_____

_____

Additional notes / Info relevant to the Social Security claim: