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ATTORNEYS AT LAW

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CHARLES W. INGMAN (1953-1996)

SSI INTERVIEW QUESTIONS

I. Background

- Full name: _____
 Mailing address: _____

 Town: _____ State: _____ Zip: _____
 Phone number: (____) _____-_____
 Age: _____
 Date of birth: ____/____/_____
 Social Security Number: _____-____-_____
- Last notice received from Social Security: Initial Reconsideration ALJ
 Date of last notice: _____
 Action taken? Appeal: Yes or No If yes, date: _____
 Any prior applications? Yes or No If so, date(s): _____
 Outcome(s) (Le., failed to appeal, appealed and lost, etc.): _____

- Marital status:

Single
 Married
 Separated: since when: _____
 Divorced x1: since when: _____
 Divorced x 2? since when: _____
 Widowed? since when: _____

Children: **Yes or No** (If the child(ren) are under the age of 18 please provide the following for potential dependant benefits.)

Name: _____ DOB: _____ SSN: _____
Name: _____ DOB: _____ SSN: _____
Name: _____ DOB: _____ SSN: _____
Name: _____ DOB: _____ SSN: _____
Name: _____ DOB: _____ SSN: _____
Name: _____ DOB: _____ SSN: _____

4. Housing situation:
Apartment, House, Duplex, Townhouse, Mobile Home
Homeless: Shelter, Living with relatives/friends, Streets
Household composition: _____

5. Current source of income: _____
Gross monthly income: _____
How long have you been receiving those benefits? _____
Does anyone in your household have a job? **Yes or No**
Who: _____
Doing what? _____
Does anyone in your household have income from another source? **Yes or No**
Who: _____
What source? _____

6. Did you go to high school? **Yes or No**
Did you graduate? **Yes or No** What year?: _____
Did you get a GED? **Yes or No** What year?: _____
What was the highest grade you completed? : _____
Why did you leave? _____
Did you repeat any grades in school or attend any special classes? **Yes or No**
Please explain: _____

7. Did you have any vocational or college training after high school? **Yes or No**
When and where: _____
What did you study? _____
Did you complete the course of study? **Yes or No**
If so, did you obtain a degree? **Yes or No**
If yes, what and when? _____
If not, why not? _____

8. Do you have any problems reading or Writing? **Yes or No**
If yes, explain: _____
Are you able to do simple arithmetic (adding/subtracting)? **Yes or No**
Can you make change easily in a store? **Yes or No**

10. Could you still perform any of the jobs that you have had in the past? **Yes or No**
Why not? _____

II. Medical

11. Are you right or left-handed? **Right or Left**
12. Height: _____
Weight: _____
What is your usual weight? _____
When did your weight change? _____

13. Do you have any diagnosed physical ailments or diseases? **Yes or No**

List them: _____

Surgeries: _____

14. What kinds of physical problems are you having now?
(for pain, describe onset of pain; frequency of pain; depth of pain on scale of 1-10; duration of pain; type of pain, including burning, throbbing, pricking, stabbing, aching; etc.)

A. HEAD (including headaches):

B. NECK, SHOULDERS:

C. BACK, SPINE:

D. CHEST, LUNGS, HEART (including shortness of breath, asthma, COPD, emphysema, vascular disease, etc.):

E. STOMACH, DIGESTIVE SYSTEM (including bowel and bladder problems; eating disorders; ulcers; liver problems; pancreas problems; etc.):

F. SKIN:

G. EXTREMITIES:

H. EPILEPSY, SEIZURE DISORDERS, OTHER NEUROLOGICAL (including Parkinson's; cerebral palsy; multiple sclerosis; muscular dystrophy; etc.):

I. BLOOD DISORDERS, CANCER:

J. ENDOCRINE PROBLEMS (including diabetes mellitus and thyroid disorders):

K. EARS, EYES, SENSORY DEFICITS (including problems with vision, hearing, speech):

15. Is your condition affected by changes in the weather? **Yes or No**
How? _____
16. Do you climb stairs every day? **Yes or No**
Do you have problems climbing stairs? **Yes or No**
What kinds of problems? _____
17. How far can you walk? _____
What happens if you try to walk farther? _____
18. How long can you stand at one time without sitting? _____
How long can you sit at one time without getting up? _____
What is the most comfortable position for you to be in? _____
19. List problems that you have:
- A. bending at the waist: _____
B. bending at the knees: _____
C. reaching overhead: _____
D. twisting: _____

III. Daily Activities

25. Describe a typical day, starting with the time you get up in the morning and ending with the time that you go to bed:

Time you get up: _____

What you do immediately after getting up: _____

How you spend the rest of the morning (include breakfast, if you eat it: what you eat, when you eat it, who prepares it; also include bathing/grooming, if appropriate): _____

Afternoon activities (include lunch, if you eat it: what you eat, when you eat it, who prepares it): _____

Evening activities (including dinner/supper, if you eat it: what you eat, when you eat it, who prepares it): _____

Time you go to bed: _____

26. Do you nap at all during the day? **Yes or No** When: _____
For how long? _____ How often? _____

27. How often do you cook for yourself or your family? _____
What do you cook? _____
Do you have any problems cooking? _____
Have your cooking habits changed (if so, how so and since when)? _____

28. Do you do the following activities? (if so, how often do you do them? If not, who does them?)

Making beds: _____

Dusting: _____

Sweeping/vacuuuming: _____

Washing dishes: _____

Laundry (do you have a washer/dryer in close proximity): _____

Yard work (mowing, raking, shoveling snow): _____

29. Who buys the groceries for your household? _____

Do you go to a big grocery store (Cub, etc.) or a small one? **Big or Small**

How often do you go? _____

Alone or with someone? _____

Do you walk up and down all of the aisles? _____

Do you carry the grocery bags? _____

Do you put the food away in the kitchen? _____

30. Do you go to church or temple? **Yes or No**

How often? _____

Do you have problems sitting through the service? **Yes or No**

Do you have problems paying attention to the service? **Yes or No**

31. Do you listen to music? **Yes or No**

What type? _____

How often? _____

32. Do you watch TV? **Yes or No**

How many hours a day? _____

What types of shows do you usually watch? _____

Do you have any problems paying attention to a program? **Yes or No**

33. Do you know how to drive a car? **Yes or No**

Do you have a license? **Yes or No**

Do you have a car? **Yes or No**

How do you usually get around? _____

How did you get here today? _____

34. With whom do you socialize? _____

How often do you have relatives visit? _____

Which relatives visit you? _____

How often do friends visit? _____

Do you visit anyone? **Yes or No**

Who? _____

How often? _____

35. What do you do for fun? _____

IV. Mental Status

36. How long does it take you to fall asleep at night? _____
Do your medications help you sleep? **Yes or No**
Once asleep, do you stay asleep? **Yes or No**
How many hours total do you sleep each night? _____
Do you ever have nightmares? **Yes or No**
How often? _____ What are they about? _____
37. Did you used to have hobbies that you don't have any longer? **Yes or No**
If yes, what hobbies? _____
When did you stop engaging in these activities? _____
Why? _____
Do you still have an interest in these activities? **Yes or No**
Do you still have the ability to participate? **Yes or No**
38. How often do you bathe? _____
How often do you change clothes? _____
Did you used to bathe and change clothes more often? **Yes or No**
39. How do you get along with other people? _____
Has your ability to get along with others changed? **Yes or No**
Since when? _____
In what way? _____
Are you:
*more irritable than you used to be? **Yes or No**
*less patient that you used to be? **Yes or No**
*more bothered by noise? **Yes or No**
40. How is your memory? _____
Long-term or short-term? _____
41. Do you ever get dizzy or confused? **Yes or No**
42. Do you have problems paying attention when people talk? **Yes or No**
43. Are you sad a lot of the time? **Yes or No**
Please describe (i.e., blue, hopeless, helpless, worthless, guilty, tearful, etc.): _____

44. Has your appetite changed? **Yes or No**
How? _____
Since when? _____

V. Chemical Dependency (if applicable)

45. How often do you drink or use drugs in a typical week? _____
What type(s) of alcohol? _____
What type(s) of drugs? _____
46. How much do you consume on days when you are drinking/using? _____