



DISABILITY HISTORY

NAME	DCN	DATE
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Pertinent Information and Observations of FSD Staff:

1. Personal Information: Age _____ Sex _____ Height _____ Weight _____

2. Highest Grade Completed: _____ GED Yes No

3a. What physical symptoms/problems do you have?

3b. What mental health symptoms/problems do you have?

Do you have crying spells or depression because of your disability? Yes No How often? _____

3c. Are your mental health symptoms due to your current circumstances (i.e. family, job, health)? Yes No

4. When did these symptoms/problems begin? _____

5. When did these symptoms first prevent you from working?

6. What are the limitations of your daily activities from this disability? Please list those you are **unable** to perform:

Able to perform?

Are you in need of caretaking? Yes No

If yes, who provides? (Check one) Nurse Relative Neighbor Friend Other:

7. Did you see a doctor or seek medical treatment for your symptoms? Yes No

Physician _____ How often? _____

Treatment received _____

When? _____

Physician _____ How often? _____

Treatment received _____

When? _____

8. Have you been given a specific diagnosis for your problem? Yes No What is the diagnosis? _____

9. Have you gone to Vocational Rehabilitation? Yes No (If yes, obtain VR reports and any medical examinations required by VR) What is the status of your Vocational Rehabilitation referral?

10. Have you applied for (check if applicable)? Social Security SSI VA
 Were you examined by a doctor for this application? Yes No (If yes, obtain medical reports from SSA)
 What is the status of your application? _____

11. Did your problem require physical therapy? Yes No (Obtain medical information or reports)
 If yes, where? When? _____
 Describe therapy: _____

12. Describe any pain you have from these problems. (If specialized care was received for this pain, obtain medical reports).

13. List medications you take, prescribed or over-the-counter, side effects and how often medication is taken:

14. Who prescribed the medications? (Obtain medical information)

15. Have you been treated by or referred to a(n):	YES	NO	REFERRED	TREATED
Orthopedist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Internist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Neurologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cardiologist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Psychologist/Psychiatrist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Other specialist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

16. Have you been hospitalized due to your disability or illness? Yes No
 If yes, where? _____
 How long? Dates? _____
 Admitting physician name? _____

Medical information **must be current** (within the past 12 months). It must include information on each of the claimant's complaints.
 If not current or complete, schedule an examination.

ADDITIONAL INFORMATION AND COMMENTS	
ITEM NO.	