MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION
DISABILITY QUESTIONNAIRE

NAME DCN DATE

Dear Applicant,

Please refer to the enclosed cover letter for instructions regarding this form. Do not return this form to your Family Support Division. We have sent you this form so that you can review the questions and make note of any items that you feel it is important for us to know about your medical condition. After you have sent in the rest of your paperwork, please call the Family Support Information Center toll free at 1-855-FSD-INFO (1-855-373-4636) and tell the Customer Service Representative that you need to speak with a MRT Specialist. You will be transferred to an MRT Specialist who will go over this form with you. If there are any questions on this form that you do not understand, the MRT Specialist will explain them to you at that time. **Do NOT return this form.**

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	☐	☐	☐	☐
Internist	☐	☐	☐	☐
Neurologist	☐	☐	☐	☐
Cardiologist	☐	☐	☐	☐
Psychologist/Psychiatrist	☐	☐	☐	☐
Other Specialist	☐	☐	☐	☐

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

ADDITIONAL INFORMATION AND COMMENTS

ITEM NO.	