MISSOURI DEPARTMENT OF SOCIAL SERVICES
FAMILY SUPPORT DIVISION

# DISABILITY QUESTIONNAIRE

Save Print Reset

| NAME | DCN | DATE |
|---|---|---|
| | | |

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 | ☐ | ☐ | ☐ | ☐ |
| 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? _____

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. | |
|---|---|