

CAPITOL CITY REHABILITATION GROUP PERSONAL HISTORY QUESTIONNAIRE

PERSONAL INFORMATION

Full Name _____ SSN _____ Date _____
Address _____ City _____ Zip Code _____
Phone # (____) _____ Cell # (____) _____ Age _____ Date of Birth _____ Gender: Male Female
E-Mail Address _____ Place of Birth (city & state) _____
Where were you raised? _____
Are you Renting or Buying? _____ House _____ Apartment _____ Quarters _____ Mobile Home _____
If Active Duty, Your Address AFTER you ETS/Retire _____

FUTURE EMPLOYMENT/EDUCATIONAL PLANS

List Your Hobbies and Recreational Activities _____
List Your Reading Interests _____
What are your Career /Education Goals? _____

Have you applied for any jobs/schools? Explain _____
When and Where would you like to begin training? _____
Estimated completion time for Training? _____ Months _____ Years
Are You willing to relocate to find Employment or for Training? Yes No
Can you Drive? Yes No Do you have a current Driver's License? Yes No
Do you have any Restrictions on your Driver's License? Yes No Explain Restrictions _____
Do you have dependable transportation to get to a job and/or training? Yes No
Your primary concerns are _____

LEGAL STATUS

List and Explain Any Felonies/Misdemeanors, Charged or Convicted:

FAMILY/SUPPORT SYSTEM

Marital Status: Single _____ Married _____ Divorced _____ Separated _____
If Married, How Long? _____ Spouse's Name _____ Spouse's Age _____
Spouse's Occupation _____ Spouse's Employer _____ Spouse's Wages _____
Do you have previous marriages? Yes No If yes, how many? _____ Date of last Divorce _____

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FAMILY/SUPPORT SYSTEM

List persons residing with you:

Name _____	Relationship _____	Age _____
Name _____	Relationship _____	Age _____
Name _____	Relationship _____	Age _____
Name _____	Relationship _____	Age _____

Do you have children or other dependents NOT living with you? Yes No

If so, please list names and ages below:

Name _____	Relationship _____	Age _____
Name _____	Relationship _____	Age _____
Name _____	Relationship _____	Age _____

Your Father's Occupation _____ Father Living: Yes No Father's Level of Education _____

Your Mother's Occupation _____ Mother Living: Yes No Mother's Level of Education _____

Number of Brothers _____ Number of Sisters _____

Occupation _____ Age _____ Occupation _____ Age _____

Occupation _____ Age _____ Occupation _____ Age _____

Occupation _____ Age _____ Occupation _____ Age _____

Occupation _____ Age _____ Occupation _____ Age _____

How is your Relationship with your: Spouse _____ Children _____ Family Members _____

MONTHLY FINANCIAL SUPPORT

Total Amount of Monthly Support _____ Your Salary _____

Please list amounts received from each source: VA Disability Benefits _____

Savings _____ Child Support _____ Received Paid

Worker's Compensation _____ Spouse's Salary _____ Social Security _____

Public Assistance _____ Vocational Rehabilitation Assistance _____ Other _____

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MILITARY HISTORY/TRAINING

Present/Recent Branch _____ Date of Entry _____ Date of Discharge _____

Type of Discharge _____ Highest Rank _____

Area of Primary Training _____ Last Job Title _____

Are you in the Reserves or National Guard? Yes No Did you have earlier periods of Service? Yes No

Branch _____ Beginning Date of Prior Service _____ End Date of Prior Service _____

Did you enjoy your Military experience? Yes No

SPECIAL MILITARY COURSE

LOCATION

DATES ATTENDED

<u>SPECIAL MILITARY COURSE</u>	<u>LOCATION</u>	<u>DATES ATTENDED</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____

List special equipment or machinery you can operate _____

MEDICAL HISTORY

Note: If you are currently active duty, describe the service-connected injuries you plan to claim at your exit physical.

Date of Service Connected Injury (ies) _____ Total percent awarded _____

Station at time of injury _____ Job Title at time of Injury _____

List each injury _____

Do you have any non-service connected disabilities? Yes No

Please describe your non-service connected disabilities _____

Describe your current limitations (personal and vocational) _____

Are you currently taking any medications? Yes No

Describe any side effects from the medications: _____

Describe any problems you are having taking care of your personal needs, home activities or daily living activities:

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MEDICAL HISTORY

Describe any anticipated future medical care/treatment/surgery: _____

Have You Received Drug/Alcohol Treatment? Yes No Are You Currently Receiving Treatment? Yes No

My service connected disability is:

Improving Deteriorating Stable Fluctuates

My disability affects my ability to work by: (check all that apply)

- Causes me to miss _____ days of work per month.
- Causes me not to be able to perform my usual work activity.
- Has no effect on my ability to do any work.

During a normal work day I can be on my feet standing and/or walking:

six hours or more four to six hours less than four hours

As a result of my service connected disability I: (check all that apply)

- Take medications
- Wear braces or prosthesis (describe type) _____
- Had surgery (describe type and date) _____
- Am in therapy (describe) _____
- Am under a Doctor's care for _____
- Attend group session (type) _____
- Expect further treatment (describe) _____

My most reasonable lifting and/or carrying expectation is: (check one)

- 100 pounds occasionally, up to 50 pounds frequently
- 50 pounds occasionally, up to 25 pounds frequently
- 20 pounds occasionally, up to 10 pounds frequently
- 10 pounds or less frequently

Do you require an assistive device to walk during the day?

Wheelchair Leg Brace Cane Crutches Other, Specify _____

Check any of the following current restrictions you now have:

- Pushing and pulling movements, including arm or leg controls
- Climbing and balancing, including stairs and ladders
- Gross manipulation, including grasping, twisting, and handling
- Fine manipulation, including finger dexterity
- Bending at the waist
- Kneeling and/or crawling
- Crouching or stooping
- Reaching, including overhead or above shoulder level
- Operating motor vehicles
- Working with or around hazardous machinery
- Environmental problems such as allergies, dust, and fumes

Do you have any obvious visual or hearing problems? Yes No

Do you have any mental/emotional restrictions? Yes No

Describe: _____