

## Sample Hearing Questions

### Identifying Questions:

1. Full Name
2. Mailing Address
3. Telephone number
4. Date of Birth?
  - a. Age on day of hearing?
  - b. Age on day you became disabled?
5. Height and Weight
  - a. Is this your normal weight?
  - b. Have you had recent weight change?
6. Marital Status
7. Number of children and ages
  - a. Do your children live in your household?
8. Any current income? (including public assistance)
  - a. Any household income?
  - b. Anyone in your household receive disability/Social Security benefits?
  - c. How do you pay your bills?
9. Are you right handed or left handed?

### Education

1. Highest Level of education completed?
  - a. If less than high school,
    - i. Can you read and write?
    - ii. Complete Job Applications?
    - iii. Read a newspaper?
  - b. If foreign born,
    - i. Where was education completed and in what language?
2. Have you completed any special training or do you hold any job certifications?

### Driver's License

1. Do you have a driver's license?
  - a. If yes,
    - i. How often do you drive?
    - ii. How far do you drive?
    - iii. Do you need any special accommodations to drive?
    - iv. Did you drive to the hearing today?
    - v. Does driving cause you any problems?
  - b. If no,
    - i. Have you ever had a license?
    - ii. Why don't you have a license?
    - iii. How did you get to the hearing today?
    - iv. How do you normally get around?

### **Past Relevant Work**

1. Is the work history report an accurate representation of your work?
2. Did you perform any other work in the last 15 years for more than 3 months?
  - a. If yes, for each job
    - i. How long did you have sit, stand and walk?
    - ii. Maximum weight lifted for job?
3. Have you performed any work since alleged onset date?
  - a. If yes,
    - i. how many hours did you work per week?
    - ii. If job has ended, why?
    - iii. If still working, why couldn't you work more?
    - iv. Any special accommodations for you by the employer?
4. Unemployment (have settled prior to hearing)
  - a. Did you collect unemployment?
  - b. When did it end?
  - c. Did you have to complete a certification that you could perform work?
  - d. Why did you collect unemployment if you did not believe you could work?
5. Are you still unable to perform work today?

### **Medical Impairments**

1. Why did you have to stop work, (or if AOD is different from date stopped work), why have you been physically or mentally unable to perform work since AOD?
2. What is the most limiting or severe impairment that you have?

### **Physical Impairments: (Will be asked for each physical impairment)**

1. How long have you had problems with this impairment?
2. How does it impact your ability to perform work?
  - a. What is your Pain Level – 1-10?
    - i. At its best, with medication?
    - ii. At its worst, with medication?
  - b. Where is pain located? (Does it spread?)
  - c. What does it feel like? (Sharp, numb, etc.)
  - d. Anything make the pain better?
  - e. Anything make the pain worse?
  - f. Is the pain constant?
  - g. Do you have periods when pain is worse (time of day, year, etc.)?
3. Treatment
  - a. Who treats you for this pain, (and for how long, how often)?
  - b. Do you require any assistive devices, cane, TENS unit, etc.?
  - c. Has physical therapy or any other alternative treatment helped?
  - d. Have you required any surgeries for condition?
  - e. Do you take medication for it?
    - i. What medication?
    - ii. Any side effects from Meds?
3. Have you had any periods where the pain improved?
  - a. How long did it improve for?
  - b. What there anything that happened that caused it to get worse?
4. Any other physical impairment or pain?

## **Anxiety Disorder (12.06)**

1. Do you have Anxiety or Panic Attacks?
2. Description of attack
  - a. How do you feel during an attack?
    - i. Physically
      1. Shortness of breath?
      2. Muscle tightness, weakness?
    - ii. Mentally
      1. Racing thoughts or fear?
  - b. Do you have any warnings?
  - c. What types of things cause attacks?
    - i. Places, people, objects?
  - d. How do you stop an attack?
  - e. How long does an average attack last?
  - f. How often do you have these attacks? (How many times per day or week?)
  - g. How long does it take you to recover from attack?
    - i. Why does it take you this long?
    - ii. What do you normally have to do after an attack?
  - h. Where do they normally occur?
  - i. If you have an attack in public, what do you do?
5. Treatment
  - f. Do you see a doctor for your anxiety disorder?
    - i. Who do you treat with?
    - ii. How often do you treat?
  - g. Do you take medication for attacks?
    - iii. What do you take?
    - iv. How often do you take it?
    - v. Any side effects?
    - vi. Any substantial changes in medication amount?
    - vii. Have you had to have any changes in the type of medication?
    - viii. Does the medication completely control your symptoms?
  - h. Have you had to be hospitalized for an attack?
    - ix. How often?
    - x. What treatment did you receive?
    - xi. When were you last hospitalized?

## Depression/Affective Disorder (12.04)

1. Do you have problems with depression?
2. When did you first have problems with depression?
3. Are you currently treating with anyone for depression?
  - a. How often?
  - b. Have you had to increase or decrease treatment?
  - c. Did you treat with anyone else in the past?
4. Do you take medication for your depression?
  - a. How well does the medication control your condition?
  - b. Any side effects from medications?
  - c. Has your doctor had to increase or decrease your medication while you have been treating?
  - d. Have you had to try other medications?
    - xii. Why?
    - xiii. What other medications have you tried?
5. Have you had to seek emergency treatment or be hospitalized for your condition?
  - a. Where?
  - b. How many times?
  - c. Why?
6. Symptoms:
  - a. Memory/concentration
    - i. Reading – do you have to reread chapters?
    - ii. Television – can you watch and understand a 1 ½ hour movie in one sitting? 1 hour television show?
    - iii. Do you get lost when driving to familiar places?
    - iv. Are you able to ask for directions when you are confused or cannot complete a task?
  - b. Changes in appetite? Weight loss/gain?
  - c. Sleep problems?
  - d. Mood disturbance?
    - i. Irritability, hostility towards others?
    - ii. Difficulty getting along with family, friends, doctors, store clerks, coworkers?
      1. Do you get into fights often (verbal or physical)?
      2. Do family or friends tell you that you over react?
      3. Difficulty holding jobs down, or fired frequently?
  - e. Guilt/worthlessness. How do you feel to not be able to work or provide for family?
  - f. Social withdrawal or isolation? (Do you like to be around others?)
  - g. Obsessions or paranoia? (Do you feel that people talk about you?)
  - h. Cry for no reason?
    - i. How often?
    - ii. How long
  - i. Hallucinations
    - i. Do you see or hear things not really there? (How do you know?)
    - ii. Do they tell you to do things or hurt people?
    - iii. How often?
  - j. Have you had thoughts of hurting yourself or anyone else?
    - i. Have you made plans or acted on thoughts?

## Postural Limitations

1. Do you have any problems with sitting?
  - a. How long can you sit with your feet flat on the floor in a straight back chair before needing to change positions? (give time in minutes or hours!)
  - b. Do you usually need to lean or elevate one or both legs when sitting?
  - c. Why can't you sit longer?
  - d. What happens when you sit too long?
2. Do you have any problems with standing?
  - a. How long can you stand at one time without leaning on anything before you need to sit or lay down? (give time in minutes or hours!)
  - b. Do you need to use a cane or any other assistive device when standing?
  - c. Why can't you stand longer?
  - d. What happens, or how do you feel if you stand too long?
3. Do you have any difficulty walking?
  - a. How far can you walk before you have to stop or rest? (give feet, blocks, yards!)
  - b. Do you need a cane or other assistive device for walking?
  - c. What happens if you walk further?
4. Do you have any problems with stairs?
  - a. How do you walk down a flight of stairs? (one step at a time, etc.)
  - b. Does it take longer than it used to?
5. Do you need to lay down during the day?
  - a. How long do you lay down at a time? (give minutes or hours!)
  - b. How many times do you lay down in the first 8 hours you are awake?
  - c. Why do you have to lay down?
6. What position are you in for most of the day? (What percentage of time in that position?)
7. Can you bend down at the waist and pick something off of the floor?
  - a. How would you pick an object off of the floor? (For example \$20 bill?)
8. Can you kneel?
9. Do you have any problems with lifting?
  - a. What is the heaviest thing you can lift? (gallon of milk? Give pounds!)
    - i. Can you carry that item across a room this size?
    - ii. What would happen if you lifted something heavier?
    - iii. Could you lift an item this heavy several times per day?
  - b. Do you use both hands or arms to lift objects?
10. Do you have any difficulty gripping with your hands?
  - a. Can you pick a coin up off a flat surface?
  - b. Can you hold a coffee cup?
  - c. Can you button buttons?
  - d. Can you comb your hair?
  - e. Can you open a jar?
  - f. Do you have difficulty writing?
11. Do you have any problems reaching?
  - a. Can you lift off of shelves?
  - b. Do you have problems using a steering wheel?
12. Does whether or temperature changes cause you problems?

## Daily Activities

1. How often do you leave your home?
  - a. Do you usually go out by yourself?
  - b. How do you usually travel when you go out (drive, ride, walk?)?
  - c. Where do you go?
  - d. How long is the longest you remain out of your home?
    - i. How did this make you feel?
    - ii. Could you do this multiple times per week?
  - e. What do you have to do when you return home? (Lay down? Sleep?)
  - f. How do you feel when you return home?
2. Do you have good days and bad days?
  - a. What is the difference between a good day and bad day?
  - b. What is the most ambitious thing you will attempt on a good day?
  - c. Most ambitious thing on a bad day?
  - d. Would you go to a doctor's appointment on a bad day?
  - e. How often do you have bad days? (per week or month)
3. Do you have any problems caring for personal hygiene?
  - a. Do you take a bath or shower everyday?
    - i. How often do you?
  - b. Do you ever have to be reminded to shower or change clothes?
  - c. Do you get dressed every day?
  - d. Do you groom your hair everyday?
  - e. Any difference in these activities based on pain, or good day or bad day?
4. Do you ever have to miss a doctors appointment?
  - i. Why?
  - ii. How often in a month?
  - iii. Do you call and cancel?
5. Do you do any chores in or out of your home? (Cleaning, cooking, laundry, yard work)
  - a. How often do you do chores?
  - b. Can you complete a chore without taking a break to rest?
  - c. Does it take you longer to complete a chore than it did in the past?
  - d. Are there chores you can't do? (laundry, cooking, vacuuming)
  - e. Did you used to do more chores?
6. Are you able to manage your own finances?
  - a. Do you pay your bills?
  - b. Balance your checkbook? (Do you make mistakes?)
7. Do you visit with friends or family?
  - a. How often and where?
8. Do you go shopping or pick up groceries?
  - a. How often?
  - b. Do you need help?
  - c. Do you ever get into verbal altercations while out?
9. Do you attend movies, church, or sporting events?
  - a. How often?
  - b. When was the last time?
  - c. How did it make you feel?
10. Do you have any hobbies?
  - a. How often do you take part in hobbies?
  - b. Any changes in your hobbies since you have been unable to work?

**Children**

1. If has children:
  - a. Are you able to attend school or sports events?
  - b. Do you have to assist your children with dressing, etc?
  - c. Do you have help with children?
  - d. Are you able to assist children with homework?
  - e. Do you ever need to ask friends or family to care for children?
  - f. Do you ever have to lift your children? (How much do they weigh?)

**Drugs and Alcohol**

1. Have you had to get treatment for drug or alcohol problems?
  - a. If yes,
    - i. When did you last use drugs or alcohol?
    - ii. Did your condition change (better or worse) after you stopped?
    - iii. Have you had any slip ups?
    - iv. Do you attend AA, or any other support group?
    - v. Why did you use drugs or alcohol?
    - vi. Did it help you feel better?

**Closing Questions**

1. What are your plans for the future?
  - a. Do you plan on returning to work?
  - b. Have you tried vocational rehabilitation?
  - c. Any future treatment you are contemplating?
2. Anything else you would like to tell the Judge?
  - a. How disability has impacted your life?
  - b. How the benefits will help your condition improve?
  - c. Why you applied for disability benefits?