

Service Questionnaire



If you need assistance completing this form please call your vocational rehabilitation office before your intake appointment.

This document can be provided upon request in an alternate format for individuals with disabilities or in a language other than English for people with limited English skills. To request this form in another format or language, contact Vocational Rehabilitation at 503-945-5880 or email vr.info@state.or.us or 711 for TTY.

Personal information					
Last name:		First name:		Middle name:	
Preferred name:		Previous last name:		Birthdate:	
Email address:		Gender:		Social Security Number: - -	
Phone number <input type="checkbox"/> cell <input type="checkbox"/> land <input type="checkbox"/> other:		Second phone number: <input type="checkbox"/> cell <input type="checkbox"/> land <input type="checkbox"/> other:			
Home address:				Date residency began:	
City:		State:	County:	ZIP code:	
Mailing address (if different than above home address):					
City:		State:		ZIP code:	
Racial and ethnic background (check all that apply):					
<input type="checkbox"/> American Indian or Alaskan Native		<input type="checkbox"/> Native Hawaiian or other Pacific Islander			
<input type="checkbox"/> Asian		<input type="checkbox"/> White			
<input type="checkbox"/> Black or African American		<input type="checkbox"/> Other (specify): _____			
<input type="checkbox"/> Hispanic or Latino					
Primary language (check all that apply):					
<input type="checkbox"/> English		<input type="checkbox"/> Spanish		<input type="checkbox"/> Other:	
Counselor notes:					
Have you been a prior client of Vocational Rehabilitation? <input type="checkbox"/> Yes <input type="checkbox"/> No					
If yes, when and where? _____					

Personal information

Are you a US citizen? ☐ Yes ☐ No If no, do you have a work permit? ☐ Yes ☐ No

Contacts:

Name:	Relationship:	Phone number:
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Name:	Relationship:	Phone number:
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Counselor notes:

Your living situation:

- | | |
|---|---|
| <input type="checkbox"/> Community residential/group home | <input type="checkbox"/> Halfway house (<i>transition living</i>) |
| <input type="checkbox"/> Homeless/shelter | <input type="checkbox"/> Live with parents |
| | <input type="checkbox"/> Private residence (<i>independent</i>) |

Marital status: ☐ Never ☐ Married ☐ Divorced
☐ Separated ☐ Widowed ☐ Domestic partner

Members living with you (*check all that apply*):

☐ Self only ☐ Self/partner and/or children ☐ Parents ☐ Other: _____

Who referred you to this agency? _____

Income

Monthly average income:

Amount:

How do you currently support yourself financially?

Social Security Income (SSI): _____

Social Security Disability Income (SSDI): _____

Temporary Assistance for Needy Families (TANF): _____

Supplemental Nutrition Assistance Program (SNAP): _____

Subtotal:

	Source:	Program:	Amount:
Workers' compensation:	_____	<input type="text"/>	_____
Veterans:	_____	<input type="text"/>	_____
Personal income:	_____	<input type="text"/>	_____
Other:	_____	<input type="text"/>	_____
Total:			<input type="text"/>

Counselor notes:

Medical insurance information

Check all that apply:

- | | | |
|--|--|--|
| <input type="checkbox"/> Medicaid | <input type="checkbox"/> Private insurance (<i>other</i>) | <input type="checkbox"/> Workers' compensation |
| <input type="checkbox"/> Medicare | <input type="checkbox"/> Private insurance (<i>own employer</i>) | <input type="checkbox"/> None |
| <input type="checkbox"/> OHP (<i>Oregon Health Plan</i>) | <input type="checkbox"/> Public insurance (<i>other</i>) | |

Counselor notes:

Employment

Are you currently employed? ☐ Yes ☐ No Hours per week: _____ Salary: _____
 Hourly wage: _____ Are you a migrant or seasonal farm worker? ☐ Yes ☐ No

Please list the most recent job you had first.

Employer 1:	Job title:
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Job duties:

Did you have any difficulties with these duties because of your disability? ☐ Yes ☐ No
If yes, how?

Start date:	End date:	Last salary/pay rate:	<input type="checkbox"/> Full time <input type="checkbox"/> Part time
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Reason for leaving: ☐ Terminated ☐ Laid off ☐ Quit ☐ Relocated/moved ☐ Other
 (*Please explain*): _____

Employer 2:	Job title:
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Job duties:

Did you have any difficulties with these duties because of your disability? ☐ Yes ☐ No
If yes, how?

Start date:	End date:	Last salary/pay rate:	<input type="checkbox"/> Full time <input type="checkbox"/> Part time
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Reason for leaving: ☐ Terminated ☐ Laid off ☐ Quit ☐ Relocated/moved ☐ Other
 (*Please explain*): _____

Employment

Employer 3:

Job title:

Job duties:

Did you have any difficulties with these duties because of your disability? ☐ Yes ☐ No

If yes, how?

Start date:

End date:

Last salary/pay rate:

☐ Full time

☐ Part time

Reason for leaving: ☐ Terminated ☐ Laid off ☐ Quit ☐ Relocated/moved ☐ Other

(Please explain):

Employer 4:

Job title:

Job duties:

Did you have any difficulties with these duties because of your disability? ☐ Yes ☐ No

If yes, how?

Start date:

End date:

Last salary/pay rate:

☐ Full time

☐ Part time

Reason for leaving: ☐ Terminated ☐ Laid off ☐ Quit ☐ Relocated/moved ☐ Other

(Please explain):

Employer 5:

Job title:

Job duties:

Did you have any difficulties with these duties because of your disability? ☐ Yes ☐ No

If yes, how?

Start date:

End date:

Last salary/pay rate:

☐ Full time

☐ Part time

Reason for leaving: ☐ Terminated ☐ Laid off ☐ Quit ☐ Relocated/moved ☐ Other

(Please explain):

Counselor notes:

Employment

Are you a veteran? ☐ Yes ☐ No Were you injured during your service? ☐ Yes ☐ No

Are you receiving services from Veteran Affairs Vocational Rehabilitation? ☐ Yes ☐ No

Have you ever had a workers' compensation claim? ☐ Yes ☐ No ☐ Pending

If yes, what state? _____

Are you a preferred worker in Oregon? ☐ Yes ☐ No

Disability information

Please list your health conditions/disability(ies)/diagnosis(es) (*physical, mental or emotional*) in the order it most affects you.

Condition:	Year of onset	How it affects me:
1.		
2.		
3.		
4.		
5.		

Please list any medications that you are **currently** taking for any of the conditions listed above:

Medication:	Purpose:
1.	
2.	
3.	
4.	
5.	

Counselor notes:

Special programs

(check all that you are involved with)

- | | |
|---|--|
| <ul style="list-style-type: none"> <input type="checkbox"/> Adult Education and Literacy Programs <input type="checkbox"/> Adult Parole/Probation <input type="checkbox"/> Alcohol and Drug <input type="checkbox"/> Alcohol and Drug — Youth <input type="checkbox"/> American Indian VR Services Program <input type="checkbox"/> Career Workforce Skills Training <input type="checkbox"/> Center for Independent Living <input type="checkbox"/> Child Protective Services <input type="checkbox"/> Community Rehabilitation Program <input type="checkbox"/> Consumer Organization or Advocacy Group <input type="checkbox"/> DD Brokerage <input type="checkbox"/> DD County Case Management <input type="checkbox"/> DOL Employment and Training Service Programs <input type="checkbox"/> Educational Institution
(<i>elementary/secondary</i>) <input type="checkbox"/> Educational Institution (<i>post-secondary</i>) <input type="checkbox"/> Employed Persons with Disability <input type="checkbox"/> Employer <input type="checkbox"/> Employment Network (<i>not otherwise listed</i>) <input type="checkbox"/> Employment Transition Services <input type="checkbox"/> Experience Works <input type="checkbox"/> Federal Student Aid (<i>pell grant, SEOG, work study, etc.</i>) <input type="checkbox"/> General assistance <input type="checkbox"/> Independent Living Services | <ul style="list-style-type: none"> <input type="checkbox"/> Intellectual and Developmental Disabilities Agency <input type="checkbox"/> Juvenile Parole/Probation <input type="checkbox"/> Latino Connection-Easter Seals <input type="checkbox"/> Medical Health Provider (<i>public or private</i>) <input type="checkbox"/> Mental Health Provider (<i>public or private</i>) <input type="checkbox"/> One-Stop Employment/Training Center <input type="checkbox"/> Other State Agency <input type="checkbox"/> Other VR State Agency <input type="checkbox"/> Public Housing Authority <input type="checkbox"/> School — not Youth Transition Program (YTP) <input type="checkbox"/> Schools Youth Transition Program <input type="checkbox"/> Seasonal Farm Workers (SFW) <input type="checkbox"/> SSA (<i>Disability Determination Service or district office</i>) <input type="checkbox"/> State Department of Correction/
Juvenile Justice <input type="checkbox"/> State Employment Service Agency <input type="checkbox"/> Supported Employment <input type="checkbox"/> Temp Assistance to Needy Families (TANF) <input type="checkbox"/> Veterans Administration <input type="checkbox"/> Welfare Agency (<i>state or local government</i>) <input type="checkbox"/> Work Readiness Workshops <input type="checkbox"/> Workers' Compensation <input type="checkbox"/> Workers' Compensation (<i>special fund</i>) <input type="checkbox"/> None |
|---|--|

Please list any and all other agencies and organizations that you are currently involved with
(*Self-Sufficiency, Adults and People with Disabilities, Mental Health, etc.*):

Name of agency:	Contact person:	Phone number:

Counselor notes (*counselor see application section, page two, for benefits information*):

Additional information

What services do you think you might need from Vocational Rehabilitation to be successful at assisting you to get to or back to work? (*check all that apply.*)

☐ Learn how to look for and find work

☐ Help to decide a work goal

☐ Learn how to work with my disability

☐ Other

(*Please explain*): _____

What strengths or skills have you identified about yourself?

Counselor notes:

What type(s) of work are you interested in doing?

☐ Part time-hours per week: _____

☐ Full time

☐ Not sure

What is your current level of computer skills/knowledge?

What is your source of transportation? ☐ Bus

☐ Car

☐ Bike

☐ Other

Do you possess a valid driver's license? ☐ Yes

☐ No

Insurance

☐ Yes

☐ No

If yes, what state: _____

Additional information

Do you have a clean driving record? ☐ Yes ☐ No **If no**, please explain:

Have you ever been arrested or convicted of a felony or a misdemeanor? ☐ Yes ☐ No

If yes, please explain:

Are you currently on supervision of any type? ☐ Yes ☐ No

If yes, and you are actively supervised, please list name and phone number of probation/parole officer:

Name: _____

Phone: _____

Counselor notes:

Do you have any other current legal issues/problems? (*specify*):

Do you have any history of substance use or abuse? ☐ Yes ☐ No **If yes**, please explain:

Could you pass a drug test? ☐ Yes ☐ No **If no**, please explain:

Counselor notes:

Education information

Are you a high school graduate or do you have a GED? ☐ Yes ☐ No

If not, what is the highest grade you completed: _____

Were you in special education classes while in school? ☐ Yes ☐ No

Did you have an Individualized Education Program (IEP)? ☐ Yes ☐ No

Do you have a 504 Plan? ☐ Yes ☐ No

Were you a participant in the youth in transition program? ☐ Yes ☐ No

If yes, to any of the above questions, please indicate school name, city and state:

School name

City

State

Education information

If you attended any college/trade school or other trainings:

School name	Begin date	End date	Degree/certification or area of study

Are you currently attending college? ☐ Yes ☐ No

If yes, where do you attend college? _____

Are you currently in default on any prior student loans? ☐ Yes ☐ No

Counselor notes:

Medical information

Have you ever had a head injury or been knocked unconscious? ☐ Yes ☐ No

If yes, please explain:

Do you have any restrictions from your doctor about working? ☐ Yes ☐ No

Counselor notes:

Medical providers

Vocational Rehabilitation (VR) will need your help to get your medical records. We need them to document your medical condition(s); identify your limitations; determine if you are eligible for our program; plan work goals; and identify services you may need to help you get or keep a job. If there is not enough space, list additional providers on a separate piece of paper.

Please list all doctors, clinics, counselors or therapists you have seen in the past or are seeing now for treatment related to your disability. Include any physical exams and/or learning disability testing.

Medical provider/clinic name:

Phone number:

Address:

Treatment for:

Are you still seeing this provider? ☐ Yes ☐ No

Most recent visit: _____

Medical information

Medical provider/clinic name:

Phone number:

Address:

Treatment for:

Are you still seeing this provider? ☐ Yes ☐ No

Most recent visit: _____

Medical provider/clinic name:

Phone number:

Address:

Treatment for:

Are you still seeing this provider? ☐ Yes ☐ No

Most recent visit: _____

Medical provider/clinic name:

Phone number:

Address:

Treatment for:

Are you still seeing this provider? ☐ Yes ☐ No

Most recent visit: _____

Medical provider/clinic name:

Phone number:

Address:

Treatment for:

Are you still seeing this provider? ☐ Yes ☐ No

Most recent visit: _____

Counselor notes: