Service Questionnaire

DHS | Oregon Department of Human Services
VOCATIONAL REHABILITATION

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 ☐ cell ☐ land ☐ other:	Second phone number: ☐ cell ☐ land ☐ 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)*:

☐ American Indian or Alaskan Native
☐ Asian
☐ Black or African American
☐ Hispanic or Latino
☐ Native Hawaiian or other Pacific Islander
☐ White
☐ Other (*specify*): _____

Primary language *(check all that apply)***:**

☐ English ☐ Spanish ☐ Other:

Counselor notes:

Have you been a prior client of Vocational Rehabilitation? ☐ Yes ☐ 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:
Name:	Relationship:	Phone number:

Counselor notes:

Your living situation:

☐ Community residential/group home ☐ Halfway house (*transition living*)

☐ Homeless/shelter ☐ Live with parents ☐ Private residence (*independent*)

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:	_____		_____
Veterans:	_____	_____	_____
Personal income:	_____		_____
Other:	_____		

Total: _____

Counselor notes:

Medical insurance information

Check all that apply:

- ☐ Medicaid
- ☐ Medicare
- ☐ OHP (*Oregon Health Plan*)
- ☐ Private insurance (*other*)
- ☐ Private insurance (*own employer*)
- ☐ Public insurance (*other*)
- ☐ Workers' compensation
- ☐ None

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:

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 2:	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*): _____

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*)

- ☐ Adult Education and Literacy Programs
- ☐ Adult Parole/Probation
- ☐ Alcohol and Drug
- ☐ Alcohol and Drug — Youth
- ☐ American Indian VR Services Program
- ☐ Career Workforce Skills Training
- ☐ Center for Independent Living
- ☐ Child Protective Services
- ☐ Community Rehabilitation Program
- ☐ Consumer Organization or Advocacy Group
- ☐ DD Brokerage
- ☐ DD County Case Management
- ☐ DOL Employment and Training Service Programs
- ☐ Educational Institution (*elementary/secondary*)
- ☐ Educational Institution (*post-secondary*)
- ☐ Employed Persons with Disability
- ☐ Employer
- ☐ Employment Network (*not otherwise listed*)
- ☐ Employment Transition Services
- ☐ Experience Works
- ☐ Federal Student Aid (*pell grant, SEOG, work study, etc*.)
- ☐ General assistance
- ☐ Independent Living Services
- ☐ Intellectual and Developmental Disabilities Agency
- ☐ Juvenile Parole/Probation
- ☐ Latino Connection-Easter Seals
- ☐ Medical Health Provider (*public or private*)
- ☐ Mental Health Provider (*public or private*)
- ☐ One-Stop Employment/Training Center
- ☐ Other State Agency
- ☐ Other VR State Agency
- ☐ Public Housing Authority
- ☐ School — not Youth Transition Program (YTP)
- ☐ Schools Youth Transition Program
- ☐ Seasonal Farm Workers (SFW)
- ☐ SSA (*Disability Determination Service or district office*)
- ☐ State Department of Correction/ Juvenile Justice
- ☐ State Employment Service Agency
- ☐ Supported Employment
- ☐ Temp Assistance to Needy Families (TANF)
- ☐ Veterans Administration
- ☐ Welfare Agency (*state or local government*)
- ☐ Work Readiness Workshops
- ☐ Workers' Compensation
- ☐ Workers' Compensation *(special fund)*
- ☐ 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:

Print Reset