STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
SOCIAL HISTORY SUMMARY FOR THE DISABLED

______________________County Department of Social Services Date _________________

Claimant __________________________________ SSN __________________________

County Case # __________________________ District # _________________________

Telephone # or a number you can be reached ______________________________________

Person Providing Information and Telephone # (if different from claimant)
_______________________________________________________________________________

Nature of Disability (based on claimant’s description or statement)
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________
_______________________________________________________________________________

I. Onset of Impairment

A. Date of illness or injury began ________________________________________________

B. Date claimant stopped work ____________________________________________________

C. Date the illness or injury became disabling ________________________________________

D. If still working:
   Name of Employer _____________________________________________________________
   Supervisor’s name and telephone # ______________________________________________
   Hours worked _________________________________________________________________
   Gross earnings ________ weekly ________ monthly ________________________________

II. Claimant’s Description of Impairment

A. Indicate how the claimant describes the symptoms of the disability and how they affect his ability to work.

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_______________________________________________________________________________
_______________________________________________________________________________

DMA-5009 (08-08)
B. Describe claimant’s daily activities and explain how the impairments affect him such as seeing, hearing, speaking, reading, walking, writing, standing, breathing, sitting, using hands, arms, and other joints. Describe how his impairments limit what he can do.

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C. Worker’s Observation of Difficulties

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III. Vocational Information (include self employment)

A. Principal Job (job done the longest in 15 years prior to onset)

1. Job Title ____________________________________________ 4. Hrs./day ____________
2. Industry ____________________________________________ 5. Days/week ____________
3. Beginning date ________________________________ 6. Rate of pay/average earnings

   Ending date ________________________________ $________ per ____________

Other Jobs – List of jobs done in last 15 years prior to alleged onset date. Give approximate dates of employment (use additional sheet if necessary)

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B. Education/Highest Grade Completed ________________________________

   High School Graduate? ________________________________

   Name and address of school if known ________________________________

   Additional education _____ Type ______________ Is claimant currently attending school? ______

   Name of school and address if known ________________________________

   Can claimant read and write? ________________________________
IV. List all Medical Sources (physicians, hospitals, emergency facilities, health departments, therapists, nursing homes, clinics, mental health centers,) including names and dates seen in the last twelve months. Give hospital or clinic number, which is on hospital or clinic card or hospital bills. (Twelve months prior to and including application month, plus any future medical appointments)

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<tr>
<th>Medical Source</th>
<th>Condition Treated</th>
<th>Dates Seen at Dr.’s office, clinic, hospital</th>
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Is claimant still being treated? Yes ____ No ____

V. VR Referral ___ Yes ___ No ___ Date last seen ______________________
VR Office __________________________________________________________
Counselor’s Name ________________________ Phone # _________________

VI. If a mental impairment is alleged, if there is evidence of drug or alcohol abuse or if the person is homeless, in a shelter or in a halfway house, please give name, address and phone number of someone who can be contacted as a third party.

______________________________________________________________
______________________________________________________________
______________________________________________________________
______________________________________________________________

Signature __________________________
Title _____________________________
Telephone # ________________________