



CLIENT INFORMATION & HISTORY
OPTUM* MANAGED DISABILITY PROGRAM

Please Check One Box: Client Completed Form Prior to Start of Assessment Interview
 Assessor Completed Form During Assessment Interview

CLIENT INFORMATION				
Name (First MI Last)		Social Security #	Date of Birth	Age
Sex (M/F)	Home Phone #	Cell Phone #	Date	

OCCUPATIONAL INFORMATION
Employer: _____ Current Job Title: _____
Last Date Worked: _____ # of Years with Employer: _____ Work Schedule: _____
Job Description & Duties: _____
Workplace Issues—Problems In the Workplace
<input type="checkbox"/> Transfer, Layoff, Demotion <input type="checkbox"/> Harassment <input type="checkbox"/> Discrimination <input type="checkbox"/> Unfair Treatment <input type="checkbox"/> Conflicts with Co-Workers/Supervisors
Details: _____
Disciplinary Actions
<input type="checkbox"/> Poor Performance Evaluation <input type="checkbox"/> Verbal Counseling <input type="checkbox"/> Written Warning <input type="checkbox"/> Final Warning
Details: _____

PREVIOUS DISABILITY
<input type="checkbox"/> None
Psychiatric (specify dates of disability, lengths of disability, and reasons for disability): _____
Medical (specify dates of disability, lengths of disability, and reasons for disability): _____

HIGHEST EDUCATIONAL LEVEL ACHIEVED

CLIENT'S OR ASSESSOR'S SIGNATURE & DATE	
Signature	Date