

LEGAL OVERLOAD.COM

Disability Benefits Intake Questionnaire Form

Please return to:

P.O. Box 782
Inglewood, CA 90307

OR

jbrown@legaloverload.com
dbrown@legaloverload.com

Fax: (323) 517-2799

Name (Last, First, M.I.): _____

Address: _____

City _____ State _____ ZIP Code _____

Email _____ Phone _____

Alternate Address _____ Birthplace
(City, State, Country) _____

Age _____ Birthdate _____ Height/Weight
Without Shoes _____

What types of surgeries have you had? _____

Explain why surgery did or did not help? _____

What type of financial help do you get now? _____

Have you ever received State Disability? Yes No If yes, when? _____

Have you ever received State Unemployment? Yes No If yes, when? _____

Have you ever received GR/GA? Yes No If yes, when? _____

Have you ever worked? Yes No If yes, when did you stop working for good? _____

List of all dates you applied for Disability _____

List of all dates you were denied _____



Are you getting regular medical treatment? Yes No Does it help? Yes No

Have you ever applied for Worker's Compensation? Yes No If yes, when? _____

When did you last see a doctor? _____

What did the doctor do? _____

What did the doctor tell you about your conditions? _____

Do your medications help? Yes No How do you pay for medical care? _____

List all upcoming medical appointments _____

Have you ever been self-employed? Yes No Is your spouse self-employed? Yes No

Have you ever worked on a job where Social Security was not withheld? Yes No If yes, when? _____

Do you have any unmarried children under 18 years old? Yes No If yes, how many? _____

Did you receive monies from any of your employers after date of disability? Yes No If yes, when? _____

Are you a veteran? Yes No If yes, Date of Discharge _____

Do you receive any monies from VA? Yes No If yes, how much per month? _____

Are you a parolee? Yes No If yes, what is your CDC#? _____

Parole Officer Name _____

Parole Office Address _____

NEXT PAGE: YOUR WORK HISTORY FOR THE PAST 15 YEARS (MOST RECENT FIRST)



1. Company Name _____ Supervisor _____

Address _____ Phone _____

City _____ State _____ ZIP Code _____

Job Title _____ Start Date _____

Days Per Week _____ End Date _____

Describe Job Duties _____

Hours Per Week _____ Hourly rate of pay _____



2. Company Name _____ Supervisor _____

Address _____ Phone _____

City _____ State _____ ZIP Code _____

Job Title _____ Start Date _____

Days Per Week _____ End Date _____

Describe Job Duties _____

Hours Per Week _____ Hourly rate of pay _____

3. Company Name _____ Supervisor _____

Address _____ Phone _____

City _____ State _____ ZIP Code _____

Job Title _____ Start Date _____

Days Per Week _____ End Date _____

Describe Job Duties _____

Hours Per Week _____ Hourly rate of pay _____

4. Company Name _____ Supervisor _____

Address _____ Phone _____

City _____ State _____ ZIP Code _____

Job Title _____ Start Date _____

Days Per Week _____ End Date _____

Describe Job Duties _____

Hours Per Week _____ Hourly rate of pay _____

5. Company Name _____ Supervisor _____

Address _____ Phone _____

City _____ State _____ ZIP Code _____

Job Title _____ Start Date _____

Days Per Week _____ End Date _____

Describe Job Duties _____

Hours Per Week _____ Hourly rate of pay _____



NAME, ADDRESS, PHONE NUMBER, AND RELATIONSHIP OF A WITNESS WHO KNOWS ABOUT YOUR MEDICAL PROBLEMS:

Name _____

Address _____

Telephone _____ Email Address _____

Relation to you _____

LIST OF YOUR DISABILITY CONDITONS BELOW. DETAIL HOW EACH OF YOUR CONDITIONS PREVENTS YOU FROM WORKING OR DOING OTHER THINGS FOR YOURSELF THAT YOU WERE ABLE TO DO BEFORE YOU BECAME DISABLED. IF YOU WERE INJURED, EXPLAIN HOW INJURY OCCURRED AND IF IT WAS JOB-RELATED.

Next Page: Medical Providers' Questions From the Last Two Years:

YOUR FULL NAME (FIRST, MIDDLE, LAST) _____

NAMES OF HOSPITALS, DOCTORS, AND MEDICAL FACILITIES. GIVE THE COMPLETE ADDRESSES AND PHONE NUMBERS FOR EACH PROVIDER.	WHAT TYPE OF TREATMENT OR TEST DID YOU RECEIVE? LIST THE DATES OF YOUR FIRST AND LAST VISITS WITH THIS MEDICAL PROVIDER.
_____ _____ _____	_____ Date of First Visit _____ Date of Last Visit _____
_____ _____ _____	_____ Date of First Visit _____ Date of Last Visit _____
_____ _____ _____	_____ Date of First Visit _____ Date of Last Visit _____
_____ _____ _____	_____ Date of First Visit _____ Date of Last Visit _____
_____ _____ _____	_____ Date of First Visit _____ Date of Last Visit _____



ATTACH ADDITIONAL SHEETS (AS NEEDED), OR FILL-IN THE SUPPLEMENTAL INFORMATION SECTION BELOW TO PROVIDE GREATER DETAIL FOR ANY PART OF THIS SIX-PAGE QUESTIONNAIRE.

<p>SUPPLEMENTAL INFORMATION</p> _____ _____ _____
--

