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SOCIAL SECURITY DISABILITY INTAKE
INFORMATION QUESTIONNAIRE

Date:

Name:

Social Security #:

Mailing Address:

City:

State:

Zip Code:

Street Address (if different from above):

City:

State:

Zip Code:

How long have you lived at your current address:

Home: (____)

Cell: (____)

Height:

Weight:

Date of Birth:

Place of Birth:

Highest School Grade Completed:

High School Graduate: Yes No GED: Yes No Trade School: Yes No

Closest Living Relative:

Name:

Phone: (____)

Relationship:

Address:

City:

State:

Zip Code:

Work History

Date of Employment (approximately)	Name and address of Employer	Duties Performed
From: To:		
From: To:		
From: To:		
From: To:		
From: To:		
From: To:		

What is the last date you worked at any job?

On what date did you become disabled?

Why did you become disabled on that date?

Is this the first time you have applied for SSDI/SSI: Yes No

What is the date of your last denial letter:

List prior date/dates applied for SSDI/SSI:

Have you been turned down for disability benefits? If so, for each denial, please state when it happened and if appealed the denial?

Where did you live when you became disabled?

Is this disability application for your own social security number account? yes no

If not, then under whose account was the application made?

Name:

Social Security #:

Is your application for social security disability insurance (SSDI), based on what you paid into social security when you worked? yes no or for SSI above? yes no

Have you continuously paid into your social security account while earning money for work over the last fifteen years? yes no If no, in what years did you not pay into your social security account?

What is the benefit amount should receive monthly through social security disability?

\$ _____/month

Have you applied for or are you receiving VA disability benefits? yes no If yes, in the line of duty? yes no

What is the benefit amount you were told you would receive monthly through VA disability (if applicable)? \$ _____/month

Are you receiving long term disability benefits? yes no If yes, please state the amount: \$ _____ the state where you were awarded benefits: _____ the name of the carrier:

the dates of receipt of these benefits:

Are you receiving workers= compensation benefits? yes no If yes, please state the amount:

\$ _____ the state where you were awarded benefits: _____ the name of the carrier: _____ the dates of receipt of these benefits:

(If you workers= compensation has settled, please bring in workers= compensation settlement documents)

Are you receiving any federal disability pension? yes no If yes, please state the amount, \$ _____ the state where you were awarded benefits: _____ The dates of receipt of these benefits:

MEDICAL INFORMATION

Please list all treating medical providers, their names and telephone numbers and the dates of care provided. This means all treating physicians, hospitals, psychiatrists, mental health care facilities, and diagnostic facilities. If you have already listed this information elsewhere, please provide us with a separate list and attach it to this page.

What doctor(s) have recommended you apply for disability?

What doctor knows the most about your disabling condition(s)?

How often do you now see him or her? _

What medical testing told your doctor and you that you are disabled?

Have you ever been diagnosed with or treated for drug or alcohol abuse? yes no

If so, when _____ and where

Have you been receiving free medical care from a county or government supported facility?

yes no If yes, where:

Treating Physicians;

1. Dr. _____ Specialty:
Phone: (____) _____ Fax: (____) _____
Address: _____
City: _____ State: _____ Zip Code: _____
Approximate dates of treatment:
Frequency of treatment/visits:
2. Dr. _____ Specialty:
Phone: (____) _____ Fax: (____) _____
Address: _____
City: _____ State: _____ Zip Code: _____

Approximate dates of treatment:

Frequency of treatment/visits:

3. Dr. _____ Specialty:
Phone: (____) _____ Fax: (____) _____
Address: _____
City: _____ State: _____ Zip Code: _____

Approximate dates of treatment:

Frequency of treatment/visits:

4. Dr. _____ Specialty:
Phone: (____) _____ Fax: (____) _____
Address: _____
City: _____ State: _____ Zip Code: _____

Approximate dates of treatment:

Frequency of treatment/visits:

Treating Hospitals

1. Name:
Phone: (____) _____
Address: _____
City: _____ State: _____ Zip Code: _____
Approximate dates of treatment:
Frequency of treatment/visits:

2. Name:
Phone: (____) _____
Address: _____
City: _____ State: _____ Zip Code: _____
Approximate dates of treatment:
Frequency of treatment/visits:

Treating Facilities

Please list the contact information for the places where you had diagnostic Atests@ done, like MRI, Xray, nerve conduction study, CT scan, blood tests, etc.

1. Name:
Phone: (_____) _____
Address: _____
City: _____ State: _____ Zip Code: _____
Approximate dates of test(s) :

2. Name:
Phone: (_____) _____
Address: _____
City: _____ State: _____ Zip Code: _____
Approximate dates of test(s) :

3. Name: _____ Phone: (_____) _____
Address: _____
City: _____ State: _____ Zip Code: _____
Approximate dates of test(s) :

Treating Mental Health Facilities

1.. Name:
Phone: (_____) _____
Address: _____
City: _____ State: _____ Zip Code: _____
Approximate dates of treatment:
Frequency of treatment/visits:

2. Name:
Phone: (_____) _____
Address: _____
City: _____ State: _____ Zip Code: _____
Approximate dates of treatment:
Frequency of treatment/visits:

Medications

Please list below or attach a list of your medications, the dosage, frequency of use, prescribing physician, and side effects:

1. Medication:
Dosage:
Dr.
Side Effects: no yes, describe:
2. Medication:
Dosage:
Dr.
Side Effects: no yes; describe:
3. Medication:
Dosage:
Dr.
Side Effects: no yes; describe:
4. Medication:
Dosage:
Dr.
Side Effects: no yes; describe:
5. Medication:
Dosage:
Dr.
Side Effects: no yes; describe:

Miscellaneous

Who can testify as a witness at your disability hearing?

Name: _

Relationship:

Address:

Telephone: (____)

How long have you know this person?

What is the frequency of contact your currently have with him or her?

Have you ever been incarcerated? yes no

If so, when _____ and where:

Comments or concerns?

Are you currently represented by an attorney in your social security disability matter?

yes no; (if you are, then you must either obtain in writing your attorney's written consent to speak to us or discharge your attorney before a member of our firm will meet with you to discuss your disability case.

_____Signature of Claimant