THE LAW OFFICE OF
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SOCIAL SECURITY DISABILITY INTAKE FORM

I. Contact Information

A. Name: _____

B. Address: _____

C. SSN: _____ DOB: _____

D. Driver's License No: _____ State: _____

E. Mobile Phone: _____

F. Other Phone: _____

G. E-mail Address: _____

H. Marital Status: _____ Spouse's Name: _____

II. Disability

A. What date did you become disabled? _____

B. What date did you apply for disability benefits? _____

C. What date(s) were you denied disability benefits? _____

D. Did you apply for both SSDI and SSI or only one? _____

E. Do you know what level of appeal your case is on? _____

III. Work and Education

A. What date did you last work? _____

B. What was your last job? _____

C. What type of work have you done for the last 15 years? *Please list each employer and approximate dates of employment. Use additional paper if necessary.*

_____

**The completion of this form by a potential client does not establish an attorney-client relationship.*

_____

_____

_____

D. What is the highest grade you completed in school? _____

E. Please list all high schools and colleges you have attended and any degrees you have earned. Include approximate dates of attendance and date of degree.

_____

_____

_____

F. Have you done any vocational training? If yes, when and with whom?

_____

_____

G. Did you receive any worker's compensation benefits associated with your disability? _____

H. If so, how much per month and what dates? _____

IV. Medical

A. What are your impairments or diagnosis? _____

_____

_____

_____

B. Which doctors have treated you and are treating you for your disability? *Please list all previous and current doctors and when you saw them. Use additional paper if necessary.* _____

_____

_____

_____

C. What dates, if any, have you been to the emergency room or been admitted to the hospital for your disability? *Please list the name of the hospital and the approximate date of your visit. Use additional paper if necessary.*

_____

_____

_____

_____

D. What medications are you currently taking? _____

_____

_____

E. Do you experience any side effects from the medications you are taking? (i.e. headaches, nausea, drowsiness). Please describe. _____

_____

_____

V. Other

A. *How were your referred to our office?* _____

_____

B. Please describe any other information you believe is relevant to your claim: _____

_____

_____

VI. Attorney Use Only

A. Attorney Consultation Notes: _____