

## SOCIAL SECURITY DISABILITY INTAKE FORM

Please fill out the following form as best you can so that our representatives can better understand your unique situation.

Date of Birth:

Name (First and Last):

Address:

Email:

I grant permission for the law firm to forward confidential info to me regarding my case via email:  
YES NO

Best contact number or numbers for call back:

How did you here about us?

Highest Grade completed in school  
(any special education, repeated grades)

Can you read/write/do math?  
Yes No

Height:

Weight:

All jobs you had in the last 15 years, and the last day you worked:  
(i.e. fired, retired, walked off, quit etc..)

Present income and source:

Answer can be none as well, also include child support, food stamps etc..

Have you received Workers compensation, VA, short term, long term disability benefits?

Yes No

Marital Status

If married: Spouse name? working? Getting Disability?

Tobacco use, Alcohol use, drug use:

(not prescribed medications, i.e.. cocaine, marijuana etc..)

What prevents you from working?

Last time you saw a Doctor and why?

Are you taking prescribed medications?

Yes No

Current Insurance:

Children and their ages:

Current and prior applications status/information:

(attach additional page(s) for explanation if necessary **AND** be sure to attach copies of any relevant documentation as well)





For Each PRESCRIPTION MEDICATION you are presently taking, please complete the following chart (attach additional sheets if necessary):

Name of Medication and Dosage	Daly Amount Taken	Condition the Medication is to Treat	Name of Prescribing Doctor	Approx Date Medication was Started	Identify Any Side Effects You are Having from this Medication

List any non-medication prescriptions you are taking and how much/when/why:

