## 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)

Do you have someone representing you now? Yes No
What stage are you at currently?
Initial Filing Reconsideration Hearing Appeal
Have you ever applied for SSD or SSI previously? Yes No
What Social Security Office did you file any previous application at?
For Each doctor, chiropractor, psychologist, psychological counselor, etc. you have seen, please complete the following chart (attach additional sheets if necessary):

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Name and Address of		Date of Last	How Many	Which	Describe any Restriction of Activities
Doctor	Visit	Visit	Visits Total	Condition was	Imposed or what you were told about
				Treated	your condition
					<u> </u>

## For Each HOSPITALIZATION please complete the following chart (attach additional sheets if necessary):

Name and	Approximate	Why were you	Describe What treatment you	Names of	Describe what you were told
Address of	Dates	hospitalized	received	doctors that	about your condition
Hospital				treated you	

## For Each PRESCIPTION 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:

Please provide your work history for the past 15 years before you became unable to work. Start with the most recent job first (attach additional sheets if necessary):

Name and Address of Employer	Date of Employment	Job Duties	Hours Per Day Total	Hours Per Day	Reason for Leaving	Hours Per Week	Rate of Pay
				Sitting:			
				Standing:			
				Walking:			
				Sitting:			
				Standing:			
				Walking:			
				Sitting:			
				Standing:			
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