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CONFIDENTIAL

SOCIAL SECURITY DISABILITY QUESTIONNAIRE

NAME: _____

MAIDEN (If applicable): _____

ADDRESS: _____

DATE OF BIRTH: _____

SOCIAL SECURITY #: _____

HOME PHONE #: _____

CELL PHONE #: _____

EMAIL ADDRESS: _____

PLACE OF BIRTH: (city and state): _____

If you are born outside of the US: City and Country born: _____

Exact date of Naturalization (if applicable): _____

List all disabling conditions and when they first bothered you: _____

DATE YOU BECAME UNABLE TO WORK DUE TO YOUR CONDITION(S): _____

Is your injury or illness work related? YES / NO (circle one)

If yes, have you filed for Workers' Compensation Benefits: YES / NO (circle one)

If yes, you must complete the Workers' Compensation Questionnaire (SSA-546) at the end of this package. If you have received any Workers' Compensation benefits you must also supply copies of all Award Notices to our office.

Did you work in any capacity after your conditions first bothered you? YES / NO

If yes, please state how these areas were affected (if at all) by your condition:

Your job duties: _____ Hours worked: _____

Attendance at work: _____

Have you (or someone on your behalf) ever filed for Social Security benefits? YES / NO

If "YES", when: _____ Decision? _____

Were you in the active military or related service before 1968? YES / NO

If "YES", what were your dates of service?

From (month / year) : _____ To (month/year): _____

Have you filed for any other public benefits? YES / NO

If "YES", what benefit?: _____

WORK HISTORY

How much were your total earnings LAST YEAR: _____

How much have you earned so far THIS YEAR: _____

Did you receive any money from an employer on or after the date you became unable to work because of your disability? YES / NO (Circle one)

If "YES": how much money?: _____
 What do these earnings represent (e.g.- vacation pay, sick pay, etc) : _____

****PLEASE INCLUDE THE LAST 15 YEARS OF EMPLOYMENT****

NAME & ADDRESS OF EMPLOYER	MONTH/YEAR WORK BEGAN	MO/DAY/YEAR WORK ENDED	DAYS PER WEEK	HOURS PER DAY
JOB #1: (START WITH MOST RECENT):				

Job Title: _____

Briefly Describe Job Duties: _____

Approx. how much weight did you lift on a regular basis (including gear worn): _____

What was the largest amount that you had to lift: _____

YEARLY WAGES: _____

NAME & ADDRESS OF EMPLOYER	MONTH/YEAR WORK BEGAN	MO/DAY/YEAR WORK ENDED	DAYS PER WEEK	HOURS PER DAY
JOB #2:				

Job Title: _____

Briefly Describe Job Duties: _____

Approx. how much weight did you lift on a regular basis (including gear worn): _____

What was the largest amount that you had to lift: _____

YEARLY WAGES: _____

NAME & ADDRESS OF EMPLOYER	MONTH/YEAR WORK BEGAN	MO/DAY/YEAR WORK ENDED	DAYS PER WEEK	HOURS PER DAY
JOB #3:				

Job Title: _____

Briefly Describe Job Duties: _____

Approx. how much weight did you lift on a regular basis (including gear worn): _____

What was the largest amount that you had to lift: _____

YEARLY WAGES: _____

MARITAL HISTORY

Have you ever been married: YES / NO (circle one)

What is your spouse's name (include maiden name if applicable): _____

What is your spouse's date of birth?: _____

When were you married (day, month and year): _____

City and State married: _____

What is your spouse's Social Security Number: _____

Has the marriage ended? YES / NO (Circle one). If YES: DIVORCE / DEATH (circle one)
Date: _____

Did you have any prior marriages that lasted 10 years or longer or ended in death? YES / NO (circle one)

If YES: complete the following:

What is your spouse's name (include maiden name if applicable): _____

What is your spouse's date of birth?: _____

When were you married (day, month and year): _____

City and State married: _____

What is your spouse's Social Security Number: _____

DIVORCE / DEATH (circle one) Date: _____

DO YOU HAVE ANY CHILDREN WHO ARE NOW UNDER AGE 19? YES / NO

If YES: (1) Are they married? YES / NO

(2) Age 18 or 19 attending secondary school? YES / NO

(3) Disabled or handicapped (age 18 or over and disability began before age 22)? YES / NO

NAMES, SOCIAL SECURITY NUMBERS AND DATE OF BIRTH OF CHILDREN:

DOCTOR INFORMATION

PLEASE LIST ALL CURRENT MEDICATIONS AND WHAT THEY ARE PRESCRIBED FOR:

*******PLEASE LIST EACH TREATING PHYSICIAN SEPARATELY*******

PHYSICIAN'S NAME: _____
PHYSICIAN'S ADDRESS: _____
TELEPHONE #: _____ FAX #: _____
TYPE OF PHYSICIAN: _____
WHAT CONDITION/ ILLNESS DOES THIS DOCTOR TREAT YOU FOR? _____

How often do you see this doctor? _____
Date you **first** saw this doctor: _____
Date you **last** saw this doctor: _____

TREATMENT RECEIVED: (please include any surgery dates): _____

PHYSICIAN'S NAME: _____
PHYSICIAN'S ADDRESS: _____
TELEPHONE #: _____ FAX #: _____
TYPE OF PHYSICIAN: _____
WHAT CONDITION/ ILLNESS DOES THIS DOCTOR TREAT YOU FOR? _____

How often do you see this doctor? _____
Date you first saw this doctor: _____
Date you last saw this doctor: _____

TREATMENT RECEIVED: (please include any surgery dates): _____

HOSPITAL INFORMATION

Have you been hospitalized for this disabling condition?: YES / NO

NAME OF HOSPITAL: _____
ADDRESS: _____

Reason for hospitalization: _____

Were you an inpatient (stayed at least 1 night): YES / NO
Were you an outpatient (discharged same day): YES / NO

Date(s) of Admission & Discharge: _____

Treatment rendered (e.g.- surgery, medicine, etc.): _____

NAME OF HOSPITAL: _____
ADDRESS: _____

Reason for hospitalization: _____

Were you an inpatient (stayed at least 1 night): YES / NO
Were you an outpatient (discharged same day): YES / NO

Date(s) of Admission & Discharge: _____

Treatment rendered (e.g.- surgery, medicine, etc.): _____

******TESTING******

If you have had any of the following tests since your disabling condition began please complete the following:

MRI: body part(s): _____ date(s): _____ where done? _____

XRAY: body part(s): _____ date(s): _____ where done? _____

EKG: date(s): _____ where done? _____

EEG date(s): _____ where done? _____

Breathing Tests: date(s): _____ where done? _____

Cardiac Catheterization: date(s): _____ where done? _____

EMG/NCV: upper or lower extremities (circle one) date(s): _____ where done? _____

OTHER: _____

PHYSICAL CAPABILITIES

Has any doctor told you to limit your activities in any way? YES / NO

If yes, give name of doctor and limitations given: _____

Has any doctor told you that you're totally disabled? YES / NO

If yes, who? _____

(1) Do you do any household maintenance on a regular basis: YES / NO

(2) Did you play sports prior to your disabling condition? YES / NO

a. If yes, how has this changed since your disabling condition? _____

(3) Do you have any hobbies? YES / NO

a. If yes, what hobbies? _____

b. Has your participation changed since your disabling condition began?

(4) Do you exercise? YES / NO

a. If yes, how has your exercise changed since your disabling condition began?

b. Are your current exercises doctor prescribed? YES / NO

(5) Do you walk? YES / NO

a. If yes, how far can you walk before you have to stop and rest? _____

b. How long do you have to rest for? _____

(6) Do you have a license to drive? YES / NO

a. Do you drive? YES / NO

b. For what purposes do you drive? _____

c. How far do you drive on a regular basis: _____

d. Do you own a car? YES / NO Standard or Automatic Transmission? _____

(7) Do you have social activities? YES / NO

a. What activities? _____

b. How often? _____

c. Have these activities changed since your disabling condition began?

(8) Do you attend Church or Synagogue ? YES / NO

- a. How Often? _____
- b. Does your condition affect your attendance? _____

(9) Do you belong to fraternal or social organizations? YES / NO

- a. Name: _____
- b. How often do you go? _____
- c. Does your condition affect your attendance? _____

(10) Do you attend ball games or other events? YES / NO

- a. Which ones? _____
- b. How often do you go? _____
- c. Does your condition affect your attendance? _____

(11) DID / DO you smoke? YES / NO

(12) Is your sleep affected by your condition? YES / NO

- a. Explain: _____

EDUCATION

HIGHEST GRADE OF SCHOOL THAT YOU COMPLETED: _____

YEAR COMPLETED: _____

HAVE YOU GONE TO ANY TRADE OR VOCATIONAL SCHOOLS? YES / NO

IF YES, WHAT TYPE OF SCHOOL: _____

YEAR COMPLETED: _____

PERSONAL

HEIGHT: _____

WEIGHT: _____

Is this usual or has it changed as a result of your condition? _____

CHECK ONE: RIGHT HANDED _____ LEFT HANDED _____

PRESENT SYMPTOMS

DESCRIBE YOUR CURRENT ABILITY TO DO THE FOLLOWING:

Walk: _____

Stand: _____

Kneel: _____

Bend: _____

Sit: _____

Use Your Hands: _____

Think Clearly: _____

Deal with Others: _____

Hear: _____

See: _____

STATE EXACTLY WHERE YOU FEEL PAIN: _____

Is the pain constant or does it come and go? _____

How long does it last? _____

Does the pain cause nausea or vomiting? YES / NO

What is your most comfortable position? _____

What can you do to ease the pain, if anything? _____