THE LAW OFFICES OF
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Concentrating in Disability & Workers' Compensation Law

Social Security Disability Questionnaire

1. Full Name_____

2. Mother's Maiden Name_____

3. Mailing Address _____

4. Social Security Number_____ Date of Birth _____

5. Place of Birth_____ US Citizen _____

6. Telephone Number _____ Email _____

7. Marital Status _____ Number of Children _____ Ages_____

8. How did you hear of this office? _____

9. Date you filed 1st application _____ Date denied _____

   Date you filed reconsideration _____ Date denied _____

   Date you filed request for hearing _____

10. When did you stop working_____

11. Please list all medical conditions which prevent you from working_____

_____

_____

_____

_____

12. Have you have received medical care for these conditions? Please list all **MEDICAL PROVIDERS, COMPLETE ADDRESS AND TELEPHONE NUMBERS.**

Name of hospital and/or doctor_____

Address _____

City_____State_____ Zip Code_____

Tel. number _____

Name of hospital and/or doctor_____

Address _____

City_____State_____ Zip Code_____

Tel. number _____

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City_____State_____ Zip Code_____

Tel. number _____

Other Benefits

13. Does your employer provide short or long term disability _____

14. Have you applied for these benefits _____

15. Have you applied for welfare? EAEDC _____

16. Did you sign a lien agreeing to repay these benefits_____

    i. When did you start receiving these benefits _____ How much _____

17. Have you applied for unemployment benefits _____

    i. How long have you been on unemployment _____ How much _____

EDUCATION

18. Did you attend High school_____ Year Graduated_____

19. If you didn't graduate, year completed_____ GED?_____

20. Did you obtain further education or training _____

21. If yes, please describe _____

22. Were you ever in the military _____ if yes, list dates and branch _____

23. WORK HISTORY (Please list at least the last 15 years, most recent first)

Name of hospital and/or doctor_____

Address _____

City_____State_____ Zip Code_____

Tel. number _____

Name of hospital and/or doctor_____

Address _____

City_____State_____ Zip Code_____

Tel. number _____

Name of hospital and/or doctor_____

Address _____

City_____State_____ Zip Code_____

Tel. number _____

Name of hospital and/or doctor_____

Address _____

City_____State_____ Zip Code_____

Tel. number _____

DAILY ACTIVITIES

23. Please list your activities during the day (shopping, household chores, social activities, etc.__

_____

_____

_____

MEDICATIONS (Please list all medication – prescription and non- prescription - name, dose, and what the medication is prescribed for)

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Please list any other information you feel is important to your case _____

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