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***CONFIDENTIAL***

## SOCIAL SECURITY DISABILITY QUESTIONNAIRE

NAME: ________________________ MAIDEN (If applicable): __________________

ADDRESS: ________________________ DATE OF BIRTH: ___________________
________________________

HOME PHONE #: ____________________

SOCIAL SECURITY #: ________________ 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).
- 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:
______________________________________________________________________

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 approximate total earnings LAST YEAR: ____________________________

How much have you approximately 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: _____________________________________

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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: _____________________________________

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**DO YOU HAVE ANY CHILDREN? YES / NO ARE THEY 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

**(1) NAMES, (2) SOCIAL SECURITY NUMBERS, AND (3) DATE OF BIRTH OF CHILDREN:**

_____________________________________________________________________________________

_____________________________________________________________________________________

# DOCTOR INFORMATION

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

______________________________________________________________________________
______________________________________________________________________________
______________________________________________________________________________

**PLEASE LIST ALL TREATING DOCTORS, PHYSICAL THERAPISTS AND THERAPISTS**

**1-**

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): ____________________
______________________________________________________________________________
______________________________________________________________________________

**2-**

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): ____________________
______________________________________________________________________________

**3-**

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): ____________________
____________________
____________________

**4-**

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.): ____________________________________________

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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 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? _____________

(2) 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? _______________________________