DISABILITY QUESTIONNAIRE

Please complete this form in as much detail as possible. TODAY'S DATE: _____

NAME: _____ Age: _____

Street Address: _____

City, State, Zip: _____ Social Sec. No. _____

Telephone Numbers: _____

Telephone for friend or relative _____

Email Address: _____

Who Referred You to This Office _____

Date of Birth: _____ Height _____ Weight _____

Where were you born? City _____ State _____

Mother's maiden name: _____

If married, Spouse's name _____ Any Children under 18 years of age? Names and Ages: _____

Have you ever filed for Social Security disability benefits before? _____. If yes, when? _____

_____

YOUR INCOME: Do you receive or have you ever received any of the following:

____ Veteran's Benefits - Amount received: _____

____ Worker's Compensation Benefits - Explain _____

Attorney? _____ Settled claim? _____

____ Unemployment Compensation - When began and amount _____

____ Food Stamps/Medicaid Coverage - When began and amount _____

____ Long-Term or Short Term Disability benefits from employment - When began and amount per month _____

Does anyone else who lives in your household work? _____If so, list their monthly wages

_____

Do you have any type of health insurance? _____

Do you work a part-time job at this time? _____

If so, list type of work, hours and wages: _____

_____

YOUR EDUCATION: Highest Grade Completed _____; GED? ___ When: _____

Special or Learning Disabled classes in School?_____

Did you attend any college classes or obtain a Degree?_____

_____ Any Special Training?_____

_____

Have you ever received services from Vocational Rehabilitation? _____

_____

Were you ever in the military? If so, what branch and years _____

_____

YOUR EMPLOYMENT:

When did you stop working full time? _____

Did you work part -time after this date?_____

If so, how many hours a day_____ What rate of pay?_____

Work History: Go back 15 years and list your employment, beginning with most recent.

Name of Employer	Kind of Work	Dates Worked
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

YOUR MEDICAL HISTORY:

Describe the medical conditions and symptoms that prevent you from working:

_____

_____

_____

_____

_____

_____

_____

Any other symptoms? _____

_____

List your current treating physicians: (If you need more space, please see last page)

1) Name of doctor: _____Address:_____

_____ Phone: _____

Last seen on _____ Will see again on _____

Reason for visits _____

2) Name of doctor: _____ Address:_____

_____ Phone: _____

Last seen on _____ Will see again on _____

Reason for visits _____

3) Name of doctor: _____ Address:_____

_____ Phone: _____

Last seen on _____ Will see again on _____

Reason for visits _____

4) Name of doctor: _____ Address:_____

_____ Phone: _____

Last seen on _____ Will see again on _____

Reason for visits _____

FORMER DOCTORS OR THERAPISTS: List the names of any former physicians, therapists, chiropractors, etc. who may have medical information on you concerning your current disability:

_____

_____

Have you been hospitalized for your disability? _____ If so, please list below:

1) Name of Hospital: _____ Date Hospitalized _____

   Reason for Hospitalization: _____

2) Name of Hospital: _____ Date Hospitalized _____

   Reason for Hospitalization: _____

List your current medications:

Name	Reason	Doctor or clinic who prescribed

Any non-prescription medication, like Advil or Tylenol? _____

_____

Are you experiencing any side effects from the medications?

Name	Side effects

Has there been any change (for better or worse) in your illnesses, injuries, or conditions since you filed your disability claim?

_____

_____

_____

_____

Do you have any <u>new</u> illnesses, injuries or conditions since your filed your disability claim?

_____

_____

_____

_____

Use this space for any additional information you would like to tell us about your disability. You may also use this space to list additional physicians, hospitalizations or medications.

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____ Today's Date: _____

Your signature