SOCIAL SECURITY INTAKE FORM

Date:_____

Name:_____ Date of Birth:_____

Address:_____, MI_____

Telephone home:_____ Alternate:_____

Social Security Number:_____ Right handed or Left?_____

Spouse's Name_____ Is spouse receiving SSD or SSI?_____

Children's Name:_____ Date of Birth:_____

Children's Name:_____ Date of Birth:_____

Are any of your children receiving SSI?_____

Education:_____ Vocational Training:_____ Military Service:_____

Past Work History: (15 years)

1. Name of Last Employer:_____

   Dates of Employment:_____ Job Title:_____

   Lifting Requirements:_____ Standing/Walking:_____

   Reason for Termination:_____

2. Name of Last Employer:_____

   Dates of Employment:_____ Job Title:_____

   Lifting Requirements:_____ Standing/Walking:_____

   Reason for Termination:_____

3. Name of Last Employer:_____

   Dates of Employment:_____ Job Title:_____

Lifting Requirements:_____ Standing/Walking:_____

Reason for Termination:_____

4. Name of Last Employer:_____

Dates of Employment:_____ Job Title:_____

Lifting Requirement:_____ Standing/Walking:_____

Reason for Termination:_____

Unemployment Compensation:_____ Registered at MESC:_____

Money from any source:_____ Registered for Direct Deposit: _____

Reimbursement agreement for FIA: _____

What date did you make this application? _____

Did you make an application for SSI along with your SSD application but were denied because of finances/assets? Yes_____ No_____

Treating Physicians:

1. Dr.:_____ Date first and Last Examined:_____

2. Dr.:_____ Date first and Last Examined:_____

3. Dr.:_____ Date first and Last Examined:_____

Written restrictions imposed by any physician:_____

_____

_____

List all Hospitals/Med Centers where you have been seen and dates:

1._____

2._____

3._____

Dates of upcoming medical appointments, Name of Doctor and reason for visit:

1._____

2._____

Have you ever been involved in any other type of claim (work comp, veterans, auto, FIA, etc.)
Yes_____ No_____

If yes, State type of claim, injury involved and date claim made: _____

_____

Prior applications for Social Security? Yes_____ No_____

Date of prior application(s) and decision(s):_____

Treatment for alcohol and/or drug dependence: Yes_____ No_____

Have you ever been convicted of a crime? Yes____ No_____

If yes, please specify the crime and date(s) of conviction:_____

U.S. Citizen? Yes___ No____ If no, what is your status:_____

List injuries/ illness/ condition limiting your ability to work:

1._____

2._____

3._____

4._____

Medications:

NAME	DOSAGE	WHO PRESCRIBED	SIDE EFFECTS
1._____			

2._____

3._____

4._____

5._____

What doctor(s) would be supportive of your claim?_____

How did you hear of our firm:

Friend/Relative/Past Client: _____ Phone book: _____ TV: _____ Other:_____

Another Attorney:_____If so, state name:_____