SOCIAL SECURITY QUESTIONNAIRE

Name_____

Address_____

City, State, ZIP Code_____

Home Phone_____ Cell Phone_____ Work Phone_____

Email Address_____

Social Security No. _____ Date of Birth_____

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1. Last Date Worked At Any Job: _____

2. When did you first apply for Social Security benefits?_____
   A. Address where you applied_____
   B. If you applied more than once, when did you most recently apply for Social Security disability benefits?_____
   C. Address where you last applied_____

3. Was your most recent application denied? ◯ Yes ◯ No
   A. If yes, when was it denied? _____
   B. If yes, did you request reconsideration? ◯ Yes ◯ No
   C. If yes, when did you request reconsideration? _____

4. Was your request for reconsideration denied? ◯ Yes ◯ No
   A. If yes, when was it denied? _____
   B. If yes, did you request a hearing? ◯ Yes ◯ No
   C. If yes, when did you request a hearing? _____

5. Have you consulted with or retained another attorney to represent you for your Social Security claim? ◯ Yes ◯ No
   A. If yes, please provide the attorney's name, address and phone number:
      _____

6. Do you have copies of any medical reports from your doctor(s) regarding your condition? ◯ Yes ◯ No
   A. If yes, please send copies of each report to our office.
   B. If no, please contact your treating doctor(s) four reports and/or records instantiating your claim of disability. **IT IS YOUR RESPONSIBILITY TO GET MEDICAL DOCUMENTATION VERIFYING YOUR DISABILITY.**

7. Were/are any of your disabilities caused by an injury at work? ◯ Yes ◯ No
   A. If yes, please provide the following:
      (1) Date(s) of injury/ies: _____
      (2) Body part(s) injured: _____
      (3) Name of employer: _____
      (4) Did case settle? ◯ Yes ◯ No
         (a) When? _____
         (b) Name of attorney, if represented:
         _____

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Name_____

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MEDICAL COMPLAINTS:

1. ☐ **Back and/or Neck**
   Name & Address of Doctor: _____
   _____
   Medications: _____
2. ☐ **Hands/Arms/Wrists/Elbows**
   Name & Address of Doctor: _____
   _____
   Medications: _____
3. ☐ **Knees/Legs/Ankles/Feet**
   Name & Address of Doctor: _____
   _____
   Medications: _____
4. ☐ **Psychiatric Treatment**
   Name & Address of Doctor: _____
   _____
   Medications: _____
5. ☐ **Pulmonary (heart, lungs, asthma)**
   Name & Address of Doctor: _____
   _____
   Medications: _____
6. ☐ **High Blood Pressure**
   Name & Address of Doctor: _____
   _____
   Medications: _____
7. ☐ **Diabetes**
   Name & Address of Doctor: _____
   _____
   Medications: _____
8. ☐ **Vision**
   Name & Address of Doctor: _____
   _____
   Medications: _____

Name_____

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9. ☐ **Arthritis**

Name & Address of Doctor: _____

_____

Medications: _____

10. ☐ **Mental Disabilities (Brain Damage, Retardation)**

Name & Address of Doctor: _____

_____

Medications: _____

11. ☐ **Hearing**

Name & Address of Doctor: _____

_____

Medications: _____

12. ☐ **Internal Illness (Cancer, Leukemia, Lupus)**

Name & Address of Doctor: _____

_____

Medications: _____

13. ☐ **Other**_____

Name & Address of Doctor: _____

_____

Medications: _____

14. ☐ **Other**_____

Name & Address of Doctor: _____

_____

Medications: _____

15. ☐ **Other**_____

Name & Address of Doctor: _____

_____

Medications: _____

If you have any additional disabilities or medical conditions, please list them on the other side of this page.