SOCIAL SECURITY DISABILITY QUESTIONNAIRE

NAME: **SOC SEC NO:**

EMAIL ADDRESS: **TELEPHONE NO:**

MAILING ADDRESS: **HOW DID YOU HEAR ABOUT US?:**

What local office have you been in contact with?

☐ BUFFALO
☐ NORTH LAS VEGAS
☐ HENDERSON

PERSONAL DATA:

Age / DOB: Mother's Maiden Name: Birthplace:

Marital Status: How do you pay rent? children under 18?

Height: Weight: Normal Weight:

Special Diet? Dominant Hand: ☐ Left ☐ Right

Do you smoke?	☐Yes	☐No	How much? _____	Felony warrants?	☐Yes ☐No
Drink alcohol?	☐Yes	☐No	How much? _____	Owe Back Taxes?	☐Yes ☐No
History of alcohol use?	☐Yes	☐No	When? _____	Owe Child Support?	☐Yes ☐No
Current Drug Use?	☐Yes	☐No		Incarceration?	☐Yes ☐No
History of drug use?	☐Yes	☐No	When? _____		

NOTES:

Do you have an account on any social networking sites? (Facebook, Myspace)
☐Yes ☐No

EDUCATION:

High School: ☐ Graduated ☐ GED ☐ Non-grad: Grade last completed: _____
Special classes? ☐Yes ☐No

Describe any education after High School _____

Were you ever in the military? ☐Yes ☐No Can you read and write English? ☐Yes ☐No
If yes, have you applied for VA disability benefits? ☐Yes ☐No

WITNESS: Please list someone who know you well who would be willing to write a statement about your limitations.
Name: _____
Address:
Telephone: _____
Relationship: _____

WORK ABILITY: **IF YOU WERE OFFERED A FULL-TIME JOB *SITTING- WHY WOULDN'T YOU BE ABLE TO DO THAT JOB*?**

ESTIMATE DATES IF YOU ARE NOT SURE:
(if date doesn't apply don't worry about it)

Application Date: _____

1st Denial: _____ **1st Appeal (Reconsideration):** _____

2nd Denial: _____ **2nd Appeal (Hearing):** _____

Date you told Social Security you became disabled: _____

OTHER BENEFITS:

Received **Worker's Compensation benefits**? ☐Yes ☐No If yes, when? _____

Received **Unemployment benefits?** ☐Yes ☐No If yes, when? _____

EMPLOYMENT:

Have you ever gone to **Vocational Rehabilitation**? ☐Yes ☐No

Have you recently *tried to work or tried to find work*? ☐Yes ☐No

WHAT IS YOUR USUAL OCCUPATION(S)?	***WHEN WAS THE LAST TIME YOU WORKED FULL-TME?***
Have you ever done a job requiring mostly sitting? ☐Yes ☐No	_____/_____/_____ ***MONTH DAY YEAR***

MEDICAL CONDITIONS: **List ALL of them - even if you did not report them to Social Security. EVERYTHING is relevant**

HEALTH PROBLEM	When Problem Started	How often does it affect you?	What are the symptoms of this health problem?
	Month: _____ **Year:** _____		
	Month: _____ **Year:** _____		
	Month: _____ **Year:** _____		
	Month: _____ **Year:** _____		
	Month: _____ **Year:** _____		
	Month: _____ **Year:** _____		
	Month: _____ **Year:** _____		
	Month: _____ **Year:** _____		
	Month: _____ **Year:** _____		

MEDICATION LIST

SS#:

NAME OF MEDICATION *& DOSAGE*	YEAR FIRST PRESCRIBED	DAILY AMOUNT TAKEN	WHY DO YOU TAKE THIS MEDICATION?	NAME OF PHYSICIAN

SIDE EFFECTS OF MEDICATIONS:

HEALTH CARE PROVIDERS: ***FOR THE LAST 3 YRS*** ***INCLUDE LOCATION & APPROXMITE DATES YOU SAW Provider*** ********* ***If you are providing an update (current client) list any NEW doctors or hospitals.***

SS#:

CLINIC/HOSPITAL NAME, DOCTOR NAME, ADDRESS, PHONE NO	CURRENT MD?	Please specify the Dates of Service *("DOS")*	TYPE OF DOCTOR
CLINIC DOCTOR ADDRESS PH#	☐ YES ☐ NO	**1ST DOS:** Mo: ______ Yr: ________ **Last DOS:** Mo: ______ Yr: ________ **Next DOS:** Mo: ______ Yr: ________	
CLINIC DOCTOR ADDRESS PH#	☐ YES ☐ NO	**1ST DOS:** Mo: ______ Yr: ________ **Last DOS:** Mo: ______ Yr: ________ **Next DOS:** Mo: ______ Yr: ________	
CLINIC DOCTOR ADDRESS PH#	☐ YES ☐ NO	**1ST DOS:** Mo: ______ Yr: ________ **Last DOS:** Mo: ______ Yr: ________ **Next DOS:** Mo: ______ Yr: ________	
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