Date:_____

PLEASE PRINT CLEARLY

NAME: _____ SEX (M / F)

SPOUSE/GUARDIAN:_____

ADDRESS:_____

CITY: _____ STATE: _____ ZIP:_____

E-MAIL ADDRESS:_____@_____

PHONE ( ) _____ WORK ( ) _____

CELL PHONE OR PAGER ( )_____

DOB:_____ SS:_____

HEIGHT and WEIGHT:_____

SPOUSE DOB: _____ SS: _____

DATE AND PLACE OF MARRIAGE: _____

DATE OF DIVORCE: _____

HOW DID YOU FIND US? REFERRED BY:

TV AD: _____ YELLOW PAGES AD:_____ OTHER (explain) _____

_____ INITIAL APPLICATION FOR SS DISABILITY_____ APPEALING A DENIAL

DATE OF DENIAL_____ DATE LAST WORKED _____

DATE BECAME DISABLED:_____

HAVE YOU EVER BEEN TREATED FOR SUBSTANCE ABUSE?: _____YES _____NO

DESCRIBE NATURE OF DISABILITY _____

_____

_____

_____

LIST NAME AND ADDRESS OF ALL DOCTOR OR HEALTH CARE PROVIDERS SEEN FOR DISABILITY:

1._____

Phone No.:_____; Address:_____

DATE FIRST SEEN_____ DATE LAST SEEN_____ NEXT APPT_____

2._____

Phone No.:_____; Address:_____

DATE FIRST SEEN_____ DATE LAST SEEN_____ NEXT APPT_____

3._____

Phone No.:_____; Address:_____

DATE FIRST SEEN_____ DATE LAST SEEN_____ NEXT APPT_____

4._____

Phone No.:_____; Address:_____

DATE FIRST SEEN_____ DATE LAST SEEN_____ NEXT APPT_____

5._____

Phone No.:_____; Address:_____

DATE FIRST SEEN_____ DATE LAST SEEN_____ NEXT APPT_____

6._____

Phone No.:_____; Address:_____

DATE FIRST SEEN_____ DATE LAST SEEN_____ NEXT APPT_____

7._____

Phone No.:_____; Address:_____

DATE FIRST SEEN_____ DATE LAST SEEN_____ NEXT APPT_____

8. _____

Phone No.:_____; Address:_____

DATE FIRST SEEN_____ DATE LAST SEEN_____ NEXT APPT_____

9. _____

Phone No.:_____; Address:_____

DATE FIRST SEEN_____ DATE LAST SEEN_____ NEXT APPT_____

10. _____

Phone No.:_____; Address:_____

DATE FIRST SEEN_____ DATE LAST SEEN_____ NEXT APPT_____

LIST ALL DIAGNOSTIC TESTS (X-rays, MRI's, CT Scans etc.) TAKEN SINCE DATE BECAME DISABLED

1._____ DATE OF TEST _____

PLACE TAKEN _____REFERRING PHYSICIAN_____

2._____ DATE OF TEST _____

PLACE TAKEN _____REFERRING PHYSICIAN_____

3._____ DATE OF TEST _____

PLACE TAKEN _____REFERRING PHYSICIAN_____

4._____ DATE OF TEST _____

PLACE TAKEN _____REFERRING PHYSICIAN_____

5._____ DATE OF TEST _____

PLACE TAKEN _____REFERRING PHYSICIAN_____

6._____ DATE OF TEST _____

PLACE TAKEN _____REFERRING PHYSICIAN_____

LIST ALL HOSPITALIZATIONS OVER THE PAST TEN YEARS

1. _____ Admitted _____ Discharged _____

_____ reason for hospitalization

2. _____ Admitted _____ Discharged _____

_____ reason for hospitalization

3. _____ Admitted _____ Discharged _____

_____ reason for hospitalization

4. _____ Admitted _____ Discharged _____

_____ reason for hospitalization

LIST OF MEDICATIONS PRESENTLY TAKING, DOSAGE, WHO PRESCRIBED AND SIDE EFFECTS

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

LIST NAMES AND DATE OF BIRTH OF ALL CHILDREN

1. _____

2. _____

3. _____

4. _____

5. _____

LIST NAMES AND ADDRESSES OF ALL EMPLOYERS FOR THE PAST TEN YEARS

1. _____

POSITION _____START DATE _____ END DATE _____

HOURS PER WEEK_____DAY_____

PAY RATE: $_____(Year/Month/Week/Hour)

2. _____

POSITION _____START DATE _____ END DATE _____

HOURS PER WEEK_____DAY_____

PAY RATE: $_____(Year/Month/Week/Hour)

3. _____

POSITION _____START DATE _____ END DATE _____

HOURS PER WEEK_____DAY_____

PAY RATE: $_____(Year/Month/Week/Hour)

4. _____

POSITION _____START DATE _____ END DATE _____

HOURS PER WEEK_____DAY_____

PAY RATE: $_____(Year/Month/Week/Hour)

HIGHEST LEVEL OF EDUCATION ACHIEVED: _____YEAR_____

ADVANCED DEGREES _____

LICENSES OR CERTIFICATES HELD _____

Note to Clients:

Clients deserve to be kept informed and updated on the status of their cases. We will make a continued effort assure that you understand what is happening with your case.
Please let me know whether you prefer periodic written updates, telephone updates, e-mail updates or schedule office appointment updates. Please check your choice(s).

_____ WRITTEN UPDATES

_____ TELEPHONE UPDATES

_____ SCHEDULED IN-OFFICE APPOINTMENTS

E-MAIL UPDATES (e-mail address _____@_____)

THANK YOU