

SOCIAL SECURITY QUESTIONNAIRE

Date: _____

Full Name: _____
First, Middle, Last

Address: _____

City: _____ State: _____ Zip: _____

Home Telephone: _____ Cell Phone: _____

Email: _____

Date of Birth: _____ Social Security Number: _____

Driver's License Number: _____ Height/Weight: _____

Name of Employer: _____

Address of Employer: _____ City: _____ State: _____ Zip: _____

Spouse's Full Name: _____

Date of Birth: _____

Referred by (please circle one):

- | | | |
|-----------------|-----------------------------|-------------------|
| AARP | FINANCIAL ADVISOR | PREPAID LEGAL |
| ATTORNEY | FRIEND | PREVIOUS CLIENT |
| BAR ASSOCIATION | INDEPENDENT FINANCIAL GROUP | PROVOSTY LAW FIRM |
| BROKER | LIEN LETTERS | RADIO SHOW |
| BUS BENCH | NBI SEMINAR | SEMINARS |
| EMPLOYEE | PRESENT CLIENT | YELLOW PAGES |

OTHER _____

CHILDREN:

Names	Date of Birth
_____	_____
_____	_____
_____	_____
_____	_____

EDUCATION:

What was the last grade completed: _____

What grades did you received in school: _____

Do you have any college education: ___ Yes ___ No

Do you have any trade school education: ___Yes ___No

Do you have any military training: ___Yes ___No

Do you have any problems with reading a newspaper: ___Yes ___No

Do you have any problems with writing a letter: ___Yes ___No

Do you have any problems with doing math: ___Yes ___No

WORK EXPERIENCE IN LAST 15 YEARS:

Employer	Dates	Position	Duties
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

ACCIDENT OR ONSET OF DISABILITY:

When: _____

Where: _____

What Happened: _____

MEDICAL TREATMENT:

Name of Doctor (First & Last)	Address	Telephone	Treatment Date(s)	Medical Problem	Which Tests Were Run if any
1.					
2.					
3.					

4.					
5.					

Hospital	Address	Telephone	Treatment Dates	Medical Problem	Which tests were run, if any?
1.					
2.					
3.					
4.					
5.					

LIST ALL PAIN, DISABILITIES, MEDICAL PROBLEMS AND INJURIES:

Description	How Often	When Start	Effect of Treatment
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

1. What effect does disability have on household chores: _____

2. What effect does disability have on outdoor chores: _____

3. What effect does disability have on hobbies/physical activities: _____

4. What effect does disability have on ability to do past work: _____

MEDICATION:

Name of Drug	Dosage	Prescribing Doctor	For what Medical Problem
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_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

1. Has your medical problems gotten better, worse or the same since the initial injury? _____

2. What other sources of income do yo have and what is the monthly amount? _____

LIST OF DOCUMENTS THAT SHOULD BE BROUGHT IN FOR THE INITIAL OFFICE CONFERENCE:

1. All letters from Social Security Administration

2. All medical reports from hospitals and doctors
3. All decisions from Social Security Administration