



SOCIAL SECURITY DISABILITY

DATE: _____

Name: _____ (Age) Birthdate: (____) _____

Address: _____ Date of Injury: _____

City: _____ State: _____ Zip: _____ Claim No.: _____

Phone: (home) _____ (work) _____ (message) _____

Social Security #: _____ Spouse's Name _____ Children's ages: _____

Who referred you to our office? _____

Where did you last work? _____

Why did you stop working? _____

When did you apply for Social Security Disability? _____

Indicate last status of claim: Date 1st application denied: _____

Date request for reconsideration filed: _____ Date reconsideration denied: _____

Date request for hearing filed: _____ Date hearing scheduled: _____

Judge assigned: _____ Who are your doctors: _____

What treatment have you received: _____

Highest grade completed: _____ Job held as of last date worked: _____

Wage of last job: _____ Jobs held 15 years prior to disability: _____

Do you have a current workers' compensation claim? Claim No.: _____

Status (time loss rate): _____

Are you represented in that case? (Attorney): _____

Any prior industrial injuries? (Claim numbers): _____

Have you drawn public assistance or unemployment since you stopped working? (Details): _____

Name of DSHS caseworker/telephone number: _____

Have you applied for Social Security Disability before (when; result)? _____

Have you been represented by other attorneys in this claim (who)? _____

Other information which would assist us in evaluating your claim: _____
