

**HEIN LAW OFFICE SOCIAL SECURITY DISABILITY INTAKE**  
**INFORMATION QUESTIONNAIRE**

\*add extra pages as needed\*

\*\*no attorney-client relationship is created by completing this form\*\*

Today's Date \_\_\_\_\_

Applicant Name as It Appears on Social Security Card:

\_\_\_\_\_

Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

If you have used a different social security number in the past, please explain here: \_\_\_\_\_

\_\_\_\_\_

Is this disability application for your own social security number account?  yes  no

If not, then under whose account was the application made?

Name: \_\_\_\_\_ Social Security #: \_\_\_\_\_

Have you used a different name in the past?  yes  no If yes, explain below.

\_\_\_\_\_

Mailing Address: \_\_\_\_\_ City:

\_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Home Address (if different from above): \_\_\_\_\_ City:

\_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

How long have you lived at your current address:

PHONE: Home: (\_\_\_\_) \_\_\_\_\_ Cell: (\_\_\_\_) \_\_\_\_\_ Friend: (\_\_\_\_) \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Place of Birth: City: \_\_\_\_\_ State \_\_\_\_\_

**EDUCATION**

Highest School Grade Completed:

If you graduated high school, what year was it? \_\_\_\_\_

Were you in any special education classes?  Yes  No

High School Graduate:  Yes  No GED:  Yes  No Trade School:  Yes  No

College?  Yes  No Graduate?  Yes  No

Degree(s)? \_\_\_\_\_ What year did you graduate? \_\_\_\_\_

What was the name of the trade school or college you attended?

When was degree completed? \_\_\_\_\_

Any educational certificates?  Yes  No If yes, explain \_\_\_\_\_

## MARRIAGE

Are you currently married?  Yes  No Spouse's name: \_\_\_\_\_

Date Married \_\_\_\_\_

Spouse's SSN \_\_\_\_\_

Spouse's DOB \_\_\_\_\_

Where were you married at?

Any prior marriages?  Yes  No Prior marriage lasted 10 years or more?  Yes  No

Name at birth of former spouse \_\_\_\_\_

Place of marriage to former spouse? (city and state) \_\_\_\_\_

Place marriage ended (city and state) \_\_\_\_\_

Marriage ended by (circle one) DEATH DIVORCE ANNULMENT

Ex-spouse's age \_\_\_\_\_ OR date of birth \_\_\_\_\_

After the marriage ended, did spouse die?  Yes  No

\*\*\*If more than one ex-spouse, please provide the same information as above on a separate sheet of paper

## CHILDREN

Do you have any minor children?  Yes  No If yes, how many minor children do you have?

\_\_\_\_\_

Any children who became disabled prior to the age of 22?  Yes  No

Children unmarried, aged 18 to 19, and still attending elementary or secondary school (below college level) full time?  Yes  No

## Work History

**\*\*WE MUST SHOW WORK GOING BACK 5 YEARS FROM YOUR DATE OF DISABILITY—feel free to add an attachment**

Did you or your spouse ever work outside the U.S.?  Yes  No

Are you currently working?  yes  no

What was your last day of work? \_\_\_\_\_

<b>Date of Employment (approximately)</b>	<b>Name and address of Employer</b>	<b>Duties Performed</b>
From: To:		
From: To:		
From: To:		
From: To:		
From: To:		

For the jobs listed above, what were 1) the wages 2) hours per day worked 3) days per week worked and 4) frequency of payment (e.g. weekly, bi-weekly, monthly)? Please use the space below to explain.

On what date did you become disabled?

Why did you become disabled on that date?

Is this the first time you have applied for SSDI/SSI:  Yes  No

#### EARNINGS

What is the total for all wages and tips you earned in the last full calendar year?  
\$ \_\_\_\_\_ (an approximation is fine)

Were any wages earned outside the U.S.?  Yes  No

Did you ever work a job in the last 15 years where social security tax was not deducted?  Yes  
 No

You or any spouse ever work for a railroad?  Yes  No

#### DIRECT DEPOSIT INFO

In order for you to get your SSDI deposited into your accounts, we will need your banking information

Circle type of account: checking or savings

Account # \_\_\_\_\_ Routing # \_\_\_\_\_

#### OTHER BENEFITS

- Will you apply for Veterans Benefits too?
- Is there a Workers Comp claim you are doing as well?

#### PREVIOUS APPLICATIONS

Have you previously applied for 1) Medicare or 2) Social Security or 3) SSI?  
(circle all that apply)

What is the date of your last denial letter:

List prior date/dates applied for SSDI/SSI:

Have you been turned down for disability benefits? If so, for each denial, please state when it happened and if appealed the denial?

Are your illnesses, injuries or conditions related to work in any way?  Yes  No

Do you provide ½ support for a parent?  Yes  No



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We need medical evidence to prove a disability claim. Please list all treating medical providers, their names and telephone numbers and the dates of care provided. This means all treating physicians, hospitals, psychiatrists, mental health care facilities, and diagnostic facilities. If you have already listed this information elsewhere, please provide us with a separate list and attach it to this page.

Is there someone Social Security Administration can call who knows about your disability, like a family member or friend?  yes  no If yes→

Name \_\_\_\_\_ Relationship to you \_\_\_\_\_

Phone number \_\_\_\_\_

Same Address as you?  yes  no If no→ What address?  
\_\_\_\_\_

What doctor(s) have recommended you apply for disability?

What doctor knows the most about your disabling condition(s)?

How often do you now see him or her? \_

What medical testing has been done and when? For example, x-rays, CT scans, blood work, or

Have you ever been diagnosed with or treated for drug or alcohol abuse?  yes  no

If so, when \_\_\_\_\_ and where

Have you been receiving free medical care from a county or government supported facility?  yes  
 no If yes, where:

**These are my treating physicians;**

1. Dr. \_\_\_\_\_ Specialty:  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City:  
\_\_\_\_\_ State: \_\_\_\_\_ Zip Code:

Approximate dates of treatment:

Frequency of treatment/visits:

2. Dr. \_\_\_\_\_ Specialty:  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City:  
\_\_\_\_\_ State: \_\_\_\_\_ Zip Code:

Approximate dates of treatment:

Frequency of treatment/visits:

3. Dr. \_\_\_\_\_ Specialty:

Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Approximate dates of treatment:  
Frequency of treatment/visits:

4. Dr. \_\_\_\_\_ Specialty: \_\_\_\_\_  
Phone: (\_\_\_\_) \_\_\_\_\_ Fax: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Approximate dates of treatment:  
Frequency of treatment/visits:

**These are the hospitals where I have received care:**

1. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Approximate dates of treatment:  
Frequency of treatment/visits:

2. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Approximate dates of treatment:  
Frequency of treatment/visits:

**These are the facilities where I have been tested:**

Please list the contact information for the places where you had diagnostic Atests@ done, like MRI, Xray, nerve conduction study, CT scan, blood tests, etc.

1. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Approximate dates of test(s) :

2. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Approximate dates of test(s) :

3. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Approximate dates of test(s) :

**These are the names of the mental health facilities where I received care:**

1.. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Approximate dates of treatment:  
Frequency of treatment/visits:

2. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_  
Address: \_\_\_\_\_ City: \_\_\_\_\_  
State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Approximate dates of treatment:

Frequency of treatment/visits:

**Medications**

Please list below or attach a list of your medications, the dosage, frequency of use, prescribing physician, and side effects:

1. Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Dr.  
Side Effects:  no  yes, describe:
2. Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Dr.  
Side Effects:  no  yes; describe:
3. Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Dr.  
Side Effects:  no  yes; describe:
4. Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Dr.  
Side Effects:  no  yes; describe:
5. Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_ Dr.  
Side Effects:  no  yes; describe:

**Miscellaneous**

Who can testify as a witness at your disability hearing?

Name: \_\_\_\_\_ Relationship:

Address:

Telephone: (\_\_\_\_) \_\_\_\_\_

How long have you known this person?

What is the frequency of contact your currently have with him or her?

Have you ever been incarcerated?  yes  no If so, when \_\_\_\_\_ and where:

Comments or concerns?

Are you currently represented by an attorney in your social security disability matter?

yes  no; (if you are, then you must either obtain in writing your attorney written consent to speak to us or discharge your attorney before a member of our firm will meet with you to discuss your disability case.

Are you married?  yes  no

Name of spouse at birth: \_\_\_\_\_

Date of marriage: \_\_\_\_\_ Married in USA?  yes  no

Spouses date of birth: \_\_\_\_\_

Any children under the age of 18?  yes  no

How did you learn about us? \_\_\_\_\_

\_\_\_\_\_  
Signature of Claimant