

SOCIAL SECURITY DISABILITY INTAKE FORM FOR JUSTESEN DISABILITY LAW

Full Name: _____ SSN: _____
Address: _____ City / State / Zip: _____
Date of Birth: _____ Your Current Age: _____
Birthplace: _____
Home Phone: () _____ Cell: () _____
Fax: () _____ E-mail: _____
Do you live alone or with others? Alone / others (relationships) _____

Name of possible WITNESS who can testify at the hearing? _____

Relationship of WITNESS to you: Therapist / counselor / social worker / priest / minister /
relative / friend / other: _____ Tel # of witness: () _____

Do you speak English?: Y/ N

What is your Education (highest grade completed):

Do you have children under age 18? If Yes, give names and dates of birth: _____

ARE YOU CURRENTLY WORKING? Yes / No If Yes, explain: _____

DATE STOPPED WORKING? _____ Why did you stop?: _____

DATE YOUR DISABILITY BEGAN: _____

Prior applications for Social Security Disability? Yes / No If yes, when _____
(bring all paperwork)

Do you have an attorney now or have you in the past? Y / N Type of case? _____
Does any attorney have records about your medical condition (e.g., accidents, injuries, worker's compensation, employment issues)? Y / N If Yes, Name, Address and Telephone of attorney?:_

Do you use (circle) cane / brace / crutches / TENS / Nebulizer machine / other? _____
Doctor who ordered it? _____ When ordered? _____

CURRENT SOURCE OF INCOME

Worker's Compensation	Yes / No	If yes, dates _____ to _____	Has your case settled? Y / N
Unemployment Comp Benefits	Yes / No	If yes, dates _____ to _____	
State Assistance	Yes / No	If yes, dates _____ to _____	

WHAT MEDICAL CONDITIONS PREVENT YOU FROM WORKING?

1. _____ When diagnosed? _____ When symptoms started?: _____

What are your symptoms?: _____

Describe how your symptoms interfere with working?: _____

2. _____ When diagnosed? _____ When symptoms started?: _____

What are your symptoms?: _____

Describe how your symptoms interfere with working?: _____

3. _____ When diagnosed? _____ When symptoms started?: _____

What are your symptoms?: _____

Describe how your symptoms interfere with working?: _____

4. _____ When diagnosed? _____ When symptoms started?: _____

What are your symptoms?: _____

Describe how your symptoms interfere with working?: _____

5. _____ When diagnosed? _____ When symptoms started?: _____

What are your symptoms?: _____

Describe how your symptoms interfere with working?: _____

6. _____ When diagnosed? _____ When symptoms
started?: _____

What are your symptoms?: _____

Describe how your symptoms interfere with working?: _____

Height _____ Current Weight _____ Usual Weight _____

ALCOHOL AND DRUG USE

Do you currently drink alcohol? Yes / No If yes, how much do you drink?

Did you drink alcohol in the past? Yes / No If yes, **when did you stop?**

Do you currently use street drugs? Yes / No If yes, what drugs?

Did you use street drugs in the past? Yes / No If yes, **when did you stop?**

Will any of your current or past medical records refer to alcohol or street drugs? Yes / No