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SOCIAL SECURITY ADMINISTRATION ODAR

CLAIMANT'S WORK BACKGROUND

Claimant	Social Security Number	

B. To be completed by the claimant:

PLEASE PRINT

Start with your **current job**, and list that and any work performed **AFTER YOU BECAME DISABLED**.

Dates of Employment		Name of Employer	Job duties (describe if extra help, frequent breaks, allowed to sit)	# hours sitting	# hours stand	Heaviest weight lifted
From	To					
From	To					
From	To					
From	To					
From	To					
From	To					
From	To					
From	To					

If more space is needed use additional sheets

SOCIAL SECURITY ADMINISTRATION ODAR

CLAIMANT'S MEDICATIONS

A. To be completed by Hearing Office

Claimant and Social Security Number:	Wage Earner and Social Security Number	

B. To be completed by the claimant

PLEASE PRINT

PLEASE LIST BELOW THE PRESCRIPTION MEDICATION WHICH YOU ARE PRESENTLY TAKING, IF THE NAME OF THE MEDICATION IS NOT SHOWN ON THE PRESCRIPTION CONTAINER, YOU MAY VERIFY THE NAME WITH YOUR PHARMACIST.

NAME OF MEDICATION	DATE FIRST PRESCRIBED	DAILY AMOUNT TAKEN	REASONS FOR MEDICATION	NAME OF PHYSICIAN	*SIDE EFFECTS

*DESCRIBE IN DETAIL ANY **SIDE EFFECTS** FROM YOUR MEDICATIONS

PLEASE LIST BELOW THE NONPRESCRIPTION MEDICATION YOU ARE TAKING AND THE REASONS YOU TAKE THEM.

If more space is needed use additional sheets

Form HA-4632 (2-94)(Revised by Justesen Disability Law 6/11)

SOCIAL SECURITY ADMINISTRATION   ODAR

CLAIMANT'S RECENT MEDICAL TREATMENT

A. To be completed by Hearing Office staff

Claimant's Name:	SSN	

B. To be completed by the claimant

Please Answer the Following Questions:

1) Have you been treated or examined recently by a doctor (other than a doctor at a hospital)?   Yes   No

List the name and addresses of doctors who have treated or examined you recently.

DOCTORS' NAME(S)	ADDRESSES(ES)	DATE(S)

2) What have these doctors told you about your condition?

3) Have you been treated by doctors in the past?

DOCTORS' NAME(S)	ADDRESSES(ES)	DATE(S)

4) Have you been hospitalized or treated in an Emergency Room?   Yes   No

If so, please state the name and address of the hospital, the reasons why you were hospitalized and the nature of the treatment you received.

Name of Hospital	Address of Hospital (include zip code)	Treatment you received

If more space is needed use additional sheets

PRE-HEARING INTERVIEW COMPLETED BY__________________________________ **Date:**______

Current Telephone #?________________ Witness: __________________ Witness Telephone # ________________)
BRING WITNESS TO OUR PRE-HEARING APPOINTMENT

Activities:

Read? Y/N Watch TV? Y/N Hobbies? Y/N ____________________

Things you enjoy? Y/N Visit friends? Y/N How often? ____________________________

Drive car? Y/N Last time drove ? ____

Go out? Y/N Where?____

Do you leave the house alone? Y/N If No, why? ____

Difficulty sleeping (describe): ____

Do you use cane / crutches / brace / other _____________ If yes, who ordered it? Dr _______________________

Average number of "bad" days in a week? ____ Describe a bad day in detail: ___________________________

____

What do you do in a normal day? ____

____

If you have pain, rate the degree of pain on an average day: Back, hands,other ____________________________

1 (mild discomfort) 2 3 4 5 6 7 8 9 10 (unbearable pain)

Trouble WALKING? Y / N Why? ____

How long can you WALK without stopping? ___________________________________ Minutes / blocks

Trouble STANDING? Y / N Why?: ____

How long can you STAND without needing to sit? ____

Trouble SITTING? Y / N Why? ____

Longest time you can SIT without discomfort/pain?____

Heaviest weight can LIFT with your dominant hand? ____________________ lbs. With other?_______________

Housework (indicate if someone helps):

Cook? Y / N / With help

Wash dishes? Y / N / With help

Take out garbage? Y / N / With help

Vacuum? Y / N / With help

Food shopping? Y / N / With help

Laundry? Y / N / With Help

Dust/sweep? Y / N / With help

Heavy cleaning? Y / N / With help

Ability to care for self:

Bath or Shower? Y / N / With help

Dress oneself Y / N / With help

Get help from others (spouse / children / others)? ____

Describe:____

____

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