Ginsberg Law Offices

Social Security Disability Questionnaire

Date of intake:_____ Stage at intake:_____

AOD:_____ DLI:_____ Interviewed by:_____

DIB SSI Other:_____ W/C case (y/n):_____

Deadlines:_____

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Personal Information

Today's date:_____ How did you hear about Ginsberg Law?_____

Your Name:_____ Date of Birth:_____

Maiden name/former names:_____ Your mother's maiden name:_____

Social Security Number:_____ Marital status:_____

Your address:_____Apt. #:_____ □ Rent □ Own

City:_____ State:_____ Zip:_____ County:_____

Home phone:_____ Work phone:_____ Cell/Beeper:_____

E-Mail address:_____

Name and # of someone who could reach you in an emergency:_____

Marital status:

□ Married □ Single □ Divorced □ Widowed

If spouse or ex-spouse is deceased what is date of death?_____

Spouse's Name:_____ Date of birth:_____ E-mail:_____

Spouse's maiden/former name:_____

Spouse's social security number:_____ Spouse's work phone:_____

Spouse's home address and home phone (if different from yours):_____

_____

Education:

Last grade completed: _____ Can you read?_____ Can you write?_____

Any special training (military, vocational training, etc.)?_____

Height/Weight

Your height:_____ Your weight:_____

Names and ages of minor children:

Children's names	**Age**	**Date of birth**

Names of persons who live with you:

Name	Age	Relationship

Your Household income and support

Spouse's employment:$_____every __week __two weeks __twice a month__month__year

Do you own a bank account:_____Name of bank:_____ Acct #:_____

How do you get by every month?_____

Worker's compensation:

Does your disability arise in whole or in part from an on-the-job injury?_____

If so, please describe what happened:_____

_____

Weekly benefit: $_____Benefits started on:_____

Workers' comp insurance company:_____

Who is your workers' comp lawyer?: _____

Amount of settlement or expected date of settlement: _____

Other monthly income

Type of benefits	Monthly amount	Beginning/ending dates
VA		
AFDC		
Food Stamps		
Unemployment		
General assistance		
Other (describe)		

Assets (things you own worth more than $2000):

Describe item	Value	Comments

Social Security Claim Information:

1. When did you file your application for Social Security benefits?_____

2. Had you ever filed for benefits before?

Date/year of filing	Denied or approved?	When were you last denied

3. On your current application, what date did you claim as the date you became unable to work? _____
4. Have you received a denial notice on this current claim?_____
5. What date did your receive the denial notice?_____
    a. Please attach a copy of your last denial notice – if you have it..

Work History

1. Are you currently working full or part time?_____
2. If so, what type of work are you doing?_____
3. Have you tried to work since the onset date of your disability? _____
    a. If so, where did you try to work?_____ _____
4. Have you looked for work since the onset of your disability?_____
5. Is there any work you think you could do? _____
    a. If so, please describe the work you think you could do:_____

_____

6. Before you left your last job, did your medical problems require you to make any changes in the hours of work, the way you worked, your job duties, absences, etc.? If so, what were there changes? _____
_____

Your Past Jobs

Please list your work for the last 15 years. List most recent job first and then your next most recent job, etc.

Employer				
Address		City:	ST	Zip
Job title				
Reason for leaving				
Job description				
Dates of employment				

Employer				
Address		City:	ST	Zip
Job title				
Reason for leaving				
Job description				
Dates of employment				

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Address		City:	ST	Zip
Job title				
Reason for leaving				
Job description				
Dates of employment				

MEDICAL CONDITIONS:

Please list your health problems which make you unable to work (list them in order of severity):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

MEDICAL TREATMENT:

Are you presently under doctor's care: Yes_____ No

Is there one doctor who knows your case the best and would be willing to help us prove that you are unable to work? Which doctor?

Please list the doctors that have treated you:

Doctor		Specialty		
Address		City:	ST	Zip
First seen		Last seen		
Phone #		Will this doctor support your claim?		
Type of treatment				
How frequently do you see this doctor?				

Doctor		Specialty		
Address		City:	ST	Zip
First seen		Last seen		
Phone #		Will this doctor support your claim		
Type of treatment				
How frequently do you see this doctor?				

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Address		City:	ST	Zip
First seen		Last seen		
Phone #		Will this doctor support your claim?		
Type of treatment				
How frequently do you see this doctor?				

Hospitals

Hospital		Specialty		
Address		City:	ST	Zip
First seen		Last seen		
Phone #		Admitting doctor		
Type of treatment				
Dates of treatment				

Hospital		Specialty		
Address		City:	ST	Zip
First seen		Last seen		
Phone #		Admitting doctor		
Type of treatment				
Dates of treatment				

Hospital		Specialty		
Address		City:	ST	Zip
First seen		Last seen		
Phone #		Admitting doctor		

Type of treatment	
Dates of treatment	

Hospital			Specialty		
Address			City:	ST	Zip
First seen		Last seen			
Phone #		Admitting doctor			
Type of treatment					
Dates of treatment					

Hospital			Specialty		
Address			City:	ST	Zip
First seen		Last seen			
Phone #		Admitting doctor			
Type of treatment					
Dates of treatment					

MEDICATIONS:

Please list all of the medications you are presently taking:

Name of Drug	**Dosage**	**How often taken**	**Medical condition**	**Who is doctor?**

OVER-THE-COUNTER-MEDICATIONS

Name of Medicine	**Dosage & frequency**	**Medical condition**

Financial stress:

As a result of your being unable to work, do you experience stress, depression or other mental aggravation?

If yes, please describe:_____

_____

How much do you owe in total?_____