SOCIAL SECURITY DISABILITY QUESTIONNAIRE
ALBERS LAW OFFICE, L.L.C.

Date:_____

Name: _____ Social Security #: _____

Mailing Address: _____

Street Address (if different from above):_____

How long have you lived at your current address: _____

Phone Numbers: Home: _____ Cell:_____

Height: _____ Weight: _____ Date of Birth: _____

Place of Birth: _____ Highest School Grade Completed: _____

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

Spouse's Name_____ Social Security #:_____

Address (if different from yours):_____

Is your spouse working? □ Yes □ No

If yes, what is his/her approximate monthly GROSS (before taxes) income?_____

Number of children: _____ Ages of children:_____

Name, Address, Relationship and Telephone Number of Closest Living Relative:

Name: _____ Phone: _____Relationship: _____

Address: _____

Work History

Date of Employment (approximately)	**Name and address of Employer**	**Duties Performed**
From: To:		
From: To:		
From: To:		
From: To:		
From: To:		

What is the last date you worked at any job? _____

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

If no, 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? □ Yes □ No

If so, for each denial, please state when it happened and if appealed the denial?

Where did you live when you became disabled?_____

Is your application for social security disability insurance (SSDI), based on what you paid into social security when you worked? □ Yes □ No

Have you continuously paid into your social security account while earning money for work over the last fifteen years? □ Yes □ No

If no, in what years did you **not** pay into your social security account?_____

_____

Have you applied for or are you receiving VA disability benefits? □ Yes □ No

If yes, were you injured in the line of duty? □ Yes □ No (Please bring you VA Disability Award letter with you to your first interview with Albers Law Office, LLC)

What is the benefit amount you were told you would receive monthly through VA disability (if applicable)? $_____/month

Are you receiving long term disability benefits? □ Yes □ No If yes, please state the amount: $_____

The state where you were awarded benefits: _____

The name of the carrier: _____

The dates of receipt of these benefits:_____

Are you receiving workers' compensation benefits? □ Yes □ No If yes, please state the amount: $_____

The state where you were awarded benefits: _____

The name of the carrier:_____

The dates of receipt of these benefits: _____
(If your workers' compensation has settled, please bring in workers' compensation settlement documents)

Are you receiving any federal disability pension? □ Yes □ No If yes, please state the amount, $_____

The state where you were awarded benefits: _____

The dates of receipt of these benefits: _____

MEDICAL INFORMATION

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.

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/her?_____

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:_____
   Address:_____
   Approximate dates of treatment: _____
   Frequency of treatment/visits:_____

2. Dr. _____ Specialty:_____
   Phone:_____
   Address:_____
   Approximate dates of treatment:_____
   Frequency of treatment/visits:_____

3. Dr. _____ Specialty:_____
   Phone:_____
   Address:_____
   Approximate dates of treatment: _____
   Frequency of treatment/visits:_____

4. Dr. _____ Specialty:_____
   Phone:_____
   Address:_____
   Approximate dates of treatment: _____
   Frequency of treatment/visits:_____

5. Dr. _____ Specialty:_____
   Phone:_____
   Address:_____
   Approximate dates of treatment: _____
   Frequency of treatment/visits:_____

These are the hospitals where I have received care:

1. Name:_____ Phone: _____
   Address: _____
   Approximate dates of treatment:_____
   Frequency of treatment/visits:_____

2. Name:_____ Phone:_____
   Address:_____
   Approximate dates of treatment:_____
   Frequency of treatment/visits:_____

3. Name:_____ Phone:_____
   Address:_____
   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 tests done, like MRI, X-ray, nerve conduction study, CT scan, blood tests, etc.

1. Name:_____ Phone:_____
   Address:_____
   Approximate dates of test(s):_____

2. Name:_____ Phone:_____
   Address:_____
   Approximate dates of test(s):_____

3. Name:_____ Phone:_____
   Address:_____
   Approximate dates of test(s):_____

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

1. Name:_____ Phone:_____
   Address:_____
   Approximate dates of treatment:_____
   Frequency of treatment/visits:_____

2. Name:_____ Phone:_____
   Address:_____
   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:_____

6. Medication:_____ Dosage:_____ Dr.:_____
   Side Effects: □ no □ yes; describe:_____

7. Medication:_____ Dosage:_____ Dr.:_____
   Side Effects: □ no □ yes; describe:_____

8. Medication:_____ Dosage:_____ Dr.:_____
   Side Effects: □ no □ yes; describe:_____

9. 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 know 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's written consent to speak to us or discharge your attorney before I meet with you to discuss your disability case.)