SOCIAL SECURITY APPEAL INTAKE FORM

Today's Date:_____ Date of Birth:_____

Name: _____ _____ _____
First Middle Last

Address:_____,_____, MI_____

Telephone home:_____Alternate:_____

Email Address: _____

Social Security Number:_____Right handed or Left?_____

Spouse's Name_____Is spouse receiving SSD or SSI? _____

Dependent Child's Name:_____Date of Birth:_____

Dependent Child's Name:_____Date of Birth:_____

Are any of your children receiving SSI?_____

Highest Grade You Completed and When: _____ Special education:_____

Have you had formal vocational training:_____

Military Service with dates served and branch of service _____:_____

Past Work History: (For 15 years since you last worked): Start with your most recent job

1. Name of Employer: _____

   Dates of Employment: _____Job Title:_____

   Full-time or Part-Time: _____

   Lifting Requirements (10, 20, 30 lbs.):_____Standing/Walking:_____

   Reason for Termination:_____

2. Name of Employer:_____

   Dates of Employment:_____ Job Title:_____

Full-time or Part-Time: _____

Lifting Requirements:_____Standing/Walking:_____

Reason for Termination:_____

3. Name of Employer: _____

Dates of Employment:_____ Job Title:_____

Full-time or Part-Time: _____

Lifting Requirements:_____Standing/Walking:_____

Reason for Termination:_____

4. Name of Employer: _____

Dates of Employment: _____ Job Title:_____

Full-time or Part-Time: _____

Lifting Requirement:_____Standing/Walking:_____

Reason for Termination:_____

Since you last worked, have you applied for OR received any of the following benefits:

Unemployment Compensation:	Yes ___ No ___
Workers' Compensation:	Yes ___ No ___
Automobile no-fault benefits:	Yes ___ No ___
Short term or long term disability benefits:	Yes ___ No ___
Veteran's Benefits:	Yes ___ No ___
State Disability Assistance through DHS:	Yes ___ No ___
Unused vacation/personal time/sick pay	Yes ___ No ___
Retirement Benefits through Social Security	Yes ___ No ___
Pension or Retirement from any source	Yes ___ No ___

If yes to any of the above questions, please specify date benefits began/ended and amount received:

_____

Are you currently receiving money from any source other than listed above? _____

If yes, please detail the amount and the source of the money (child support, alimony, sick pay, etc) _____

Do you have a Disability Rating through the Veterans Administration?_____. If yes, please provide a copy of your Disability Rating/Award letter from the VA.

Do you have a child support obligation through the Friend of the Court?_____. If yes, please provide the case number(s), the county and the amount of the arrearage(s). _____
_____

Do you have any IRS liens, State tax liens or other governmental liens of any nature?_____

If yes, please provide the nature of the lien, amount of the lien and any enforcement proceedings that have been initiated or that you know will be:
_____

_____

Treating Physicians:

1. Dr._____ Address:_____

_____

Date of first, last and next appointment: _____

2. Dr._____ Address:_____

_____

Date of first, last and next appointment: _____

3. Dr._____ Address:_____

_____

Date of first, last and next appointment: _____

Written restrictions imposed by any physician: _____

_____
List all Hospitals/Med-Centers/Psychiatric Hospitals where you have been seen and dates:

1._____

2._____

3._____

Have you ever been involved in any other type of claim (work comp, veterans, auto, DHS, etc.)
Yes _____ No_____

If yes, State type of claim, injury involved and date claim made: _____

Prior applications for Social Security? Yes_____ No_____

Date of prior application(s) and/or decision(s):_____

Have you ever been overpaid by SSA? Yes _____ No _____

Have you ever been treated for alcohol and/or drug (prescription or non-prescription) dependence:
Yes_____ No_____

Do you have a medical marijuana card? Yes_____ No_____

Will your medical records note any alcohol abuse, illegal drug use or the fact that you have a medical marijuana card? Yes_____ No_____

Have you ever violated a narcotic pain medication contract with any physician's office? If yes, please provide details and date(s):

_____

_____

Have you been incarcerated ***for any length of time*** since your disability began? _____

If yes, please details with dates of incarceration:_____

Have you ever been convicted of a crime? Yes_____ No_____

If yes, please specify the crime and date(s) of conviction:_____
_____

U.S. Citizen? Yes___ No____ If no, what is your status:_____

Do you have any social media accounts such as Facebook, Twitter, Tumblr, etc? _____

_____

List injuries / conditions limiting your ability to work:

1._____

2._____

3._____

4._____

Medications:

NAME	DOSAGE	WHO PRESCRIBED	REASON	SIDE EFFECTS

1._____

2._____

3._____

4._____

5._____

What doctor(s) would be supportive of your disability claim?_____

How did you hear of our firm:

Friend/Relative/Client/Another Attorney:_____

Phone book: _____ Internet: _____ Other: _____

** Have you or a family member been involved in any type of accident in the last 2 years and sustained injuries? Yes ____ No ____

** Have you or a family member ever suffered any serious injuries from a medical procedure/treatment or from taking a prescribed medication? Yes ____ No ____

** Are you or a family member in need of legal assistance for any other matter? Yes ____ No ____