

### Client History – Social Security Claim

#### I. General Information

Name: \_\_\_\_\_ Today's Date: \_\_\_\_\_

Address: Street/P.O Box: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Telephone: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

Emergency Contact (Friend or Relative): \_\_\_\_\_

Other names used: \_\_\_\_\_ When: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Right or left handed: \_\_\_\_\_

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Is this your normal weight? \_\_\_\_\_

Gained or lost & why? \_\_\_\_\_

Marital Status: \_\_\_\_\_ Date of Marriage: \_\_\_\_\_

Spouse's name: \_\_\_\_\_ Spouse's SSN: \_\_\_\_\_

For each child under 19 years of age, please list name and date of birth:

\_\_\_\_\_  
\_\_\_\_\_

Other dependents: \_\_\_\_\_

Did you serve in the military? \_\_\_\_\_ What Branch? \_\_\_\_\_

Date of discharge: \_\_\_\_\_ Honorable? \_\_\_\_\_ Number of years: \_\_\_\_\_

#### II. Social Security History

SS Number: \_\_\_\_\_ Type of SS Claim: \_\_\_\_\_

Local SS Office: \_\_\_\_\_

Application Date: \_\_\_\_\_ Denial Date: \_\_\_\_\_

Date Reconsideration Requested: \_\_\_\_\_ Denial Date: \_\_\_\_\_

Date Hearing Requested: \_\_\_\_\_

Have you received SS benefits before? \_\_\_\_\_ When? \_\_\_\_\_

**III. Financial Status**

Do you own your home? \_\_\_\_\_ Who lives with you? \_\_\_\_\_

State the amount of income you receive from the following sources:

Disability Insurance _____	Workers Comp _____
Social Security _____	Food Stamps _____
Employment _____	Other _____

State the amount and source of your spouse's income: \_\_\_\_\_

State the amount and source of any other family income: \_\_\_\_\_

Have you received or applied for unemployment compensation since you became disabled? \_\_\_\_\_  
When? \_\_\_\_\_ Amount? \_\_\_\_\_

Have you ever drawn Worker's Comp? If yes, when, how long, and how much?  
\_\_\_\_\_

**IV. Educational History**

Highest grade completed: \_\_\_\_\_ Where: \_\_\_\_\_

GED: Yes \_\_\_\_\_ No \_\_\_\_\_ Vocational Training: Yes \_\_\_\_\_ No \_\_\_\_\_ (describe training below):  
\_\_\_\_\_

Can you read? Yes \_\_\_\_\_ No \_\_\_\_\_ Not Well \_\_\_\_\_ Newspaper \_\_\_\_\_ Magazines \_\_\_\_\_ Novels \_\_\_\_\_  
Comic Books \_\_\_\_\_ Other (describe) \_\_\_\_\_

Can you write? Yes \_\_\_\_\_ No \_\_\_\_\_ Not Well \_\_\_\_\_ Letters \_\_\_\_\_ Grocery List \_\_\_\_\_ Checks \_\_\_\_\_

Can you do math? Yes \_\_\_\_\_ No \_\_\_\_\_ Not Well \_\_\_\_\_ Make Change \_\_\_\_\_ Manage Own Finances \_\_\_\_\_

**V. Employment History**

Date Last Worked: \_\_\_\_\_ Occupation: \_\_\_\_\_

Last Employer: \_\_\_\_\_

Time with Employer: \_\_\_\_\_ From: \_\_\_\_\_

Reason for leaving last employer (be specific and detailed): \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Job Demands: (examples: lifting, bending, pushing, hours, carrying, pulling, special tools or equipment)  
\_\_\_\_\_  
\_\_\_\_\_

Supervisory Responsibility? Yes \_\_\_\_\_ No \_\_\_\_\_ (if yes, describe)  
\_\_\_\_\_  
\_\_\_\_\_

Any medical leave of absence? \_\_\_\_\_

Have you made any work attempts since disability began? \_\_\_\_\_



**VI. Medical History**

List your most severe medical problem: \_\_\_\_\_

\_\_\_\_\_

How does this medical problem affect your ability to work? \_\_\_\_\_

\_\_\_\_\_

What doctor(s) treated you for this problem? \_\_\_\_\_

\_\_\_\_\_

List your NEXT most severe medical problem: \_\_\_\_\_

\_\_\_\_\_

How does this medical problem affect your ability to work? \_\_\_\_\_

\_\_\_\_\_

What doctor(s) treated you for this problem? \_\_\_\_\_

\_\_\_\_\_

List your NEXT most severe medical problem: \_\_\_\_\_  
\_\_\_\_\_

How does this medical problem affect your ability to work? \_\_\_\_\_  
\_\_\_\_\_

What doctor(s) treated you for this problem? \_\_\_\_\_  
\_\_\_\_\_

List your NEXT most severe medical problem: \_\_\_\_\_  
\_\_\_\_\_

How does this medical problem affect your ability to work? \_\_\_\_\_  
\_\_\_\_\_

What doctor(s) treated you for this problem? \_\_\_\_\_  
\_\_\_\_\_

List your NEXT most severe medical problem: \_\_\_\_\_  
\_\_\_\_\_

How does this medical problem affect your ability to work? \_\_\_\_\_  
\_\_\_\_\_

What doctor(s) treated you for this problem? \_\_\_\_\_  
\_\_\_\_\_

List your NEXT most severe medical problem: \_\_\_\_\_  
\_\_\_\_\_

How does this medical problem affect your ability to work? \_\_\_\_\_  
\_\_\_\_\_

What doctor(s) treated you for this problem? \_\_\_\_\_  
\_\_\_\_\_

**VII. Other Medical Treatment**

Do you use a cane, brace, TENS unit, home traction unit, oxygen machine, or any other device on a regular basis? If so, please specify: \_\_\_\_\_  
\_\_\_\_\_

Doctor who prescribed device(s): \_\_\_\_\_

Do you use any type of home treatment? If so, describe: \_\_\_\_\_  
\_\_\_\_\_

Have you ever received any physical therapy? If so, state:

Physical Therapist: \_\_\_\_\_

Approximate Dates: \_\_\_\_\_

Have you ever seen a mental health professional? If so, please provide name, address, date(s) seen, and the reason: \_\_\_\_\_  
\_\_\_\_\_

Would mental health counseling help you now? \_\_\_\_\_ If yes, why?

Have you ever been to the Bureau of Vocational Rehabilitation? \_\_\_\_\_ If yes, specify counselor, address, date(s) seen, and reason: \_\_\_\_\_  
\_\_\_\_\_

Have you ever been treated by a chiropractor? \_\_\_\_\_ If yes, specify counselor, address, date(s) seen, and reason: \_\_\_\_\_  
\_\_\_\_\_

### VIII. Functional Capacity

Check "Yes" or "No" if you can or cannot do the following, and describe help needed, if any:

Get Dressed	Yes _____ No _____	Help Needed: _____
Tub Bath	Yes _____ No _____	Help Needed: _____
Shower	Yes _____ No _____	Help Needed: _____
Make Beds	Yes _____ No _____	Help Needed: _____
Cook	Yes _____ No _____	Help Needed: _____
Wash Dishes	Yes _____ No _____	Help Needed: _____
Vacuum	Yes _____ No _____	Help Needed: _____
Do Laundry	Yes _____ No _____	Help Needed: _____
Shop for Food	Yes _____ No _____	Help Needed: _____
Put out Trash	Yes _____ No _____	Help Needed: _____
Mow Lawn	Yes _____ No _____	Help Needed: _____
Garden	Yes _____ No _____	Help Needed: _____

How far can you walk? \_\_\_\_\_

How long can you stand at one time? \_\_\_\_\_ Sit at one time? \_\_\_\_\_

How long can you stand in an 8 hour period? \_\_\_\_\_

Sit in an 8 hour period? \_\_\_\_\_

Can you lift the following weights? Indicate "Yes" or "No":

_____ 5-pound bag of sugar	_____ 25 pounds
_____ 10-pound sack of potatoes	_____ 30 pounds
_____ 20 pounds	_____ 50 pounds

Can you lift and carry the following weights? Indicate "Yes" or "No":

_____ 5-pound bag of sugar	_____ 25 pounds
_____ 10-pound sack of potatoes	_____ 30 pounds
_____ 20 pounds	_____ 50 pounds

Describe any difficulties you have doing the following:

Bending \_\_\_\_\_  
 Stooping \_\_\_\_\_  
 Squatting \_\_\_\_\_  
 Crawling \_\_\_\_\_  
 Climbing Stairs \_\_\_\_\_  
 Pushing and pulling with legs or arms \_\_\_\_\_  
 Driving a car \_\_\_\_\_

**IX. Typical Day**

Describe any difficulty you have sleeping: \_\_\_\_\_  
 \_\_\_\_\_

How many hrs. do you sleep at night? \_\_\_\_\_ Do you sleep/nap the next day? \_\_\_\_\_ How long? \_\_\_\_\_

What do you do to pass time during the day? \_\_\_\_\_  
 \_\_\_\_\_

Do you have hired help (nurses, homemakers, etc.) to assist you? \_\_\_\_\_ If yes, describe:  
 \_\_\_\_\_

Do you have any hobbies? \_\_\_\_\_ If yes, please list them: \_\_\_\_\_  
 \_\_\_\_\_

Do you belong to any clubs or organizations? \_\_\_\_\_ If yes, please list them: \_\_\_\_\_  
 \_\_\_\_\_

Do you participate in church activities? \_\_\_\_\_ If yes, please list them: \_\_\_\_\_  
 \_\_\_\_\_

Please list any hobbies/other activities you had to give up as a result of your medical condition:  
 \_\_\_\_\_  
 \_\_\_\_\_

For what reasons do you leave the house? (Shopping, visiting, religious activities, appointments, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_

Do you have visitors? If so, who (relatives, friends, etc.) and how often? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Other information concerning typical day**

\_\_\_\_\_  
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**Did you need any help to complete this form?** Yes \_\_\_\_\_ No \_\_\_\_\_

If so, who helped you? \_\_\_\_\_