

## Client History – Social Security Claim - Child

### I. Child's General Information

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

Parent/Guardian's Name: \_\_\_\_\_

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? \_\_\_\_\_

### 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? \_\_\_\_\_

### 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 \_\_\_\_\_

**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? \_\_\_\_\_  
\_\_\_\_\_

**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: \_\_\_\_\_  
\_\_\_\_\_



