CLIENT HISTORY-GENERAL INFORMATION

DATE:_____

NAME:_____
ADDRESS:_____
PHONE:_____ DATE OF BIRTH:_____AGE_____

OTHER NAMES USED_____
MARITAL STATUS:_____DATE OF MARRIAGE_____

HOW MANY CHILDREN UNDER 19 YEARS OLD? _____

SS CLAIM INFORMATION

LOCAL SS OFFICE:_____
TYPE OF CLAIM:_____
HAVE YOU RECEIVED SS BENEFITS BEFORE?_____

IF YES, WHAT?_____

APPLICATION DATE:_____ DENIAL DATE:_____
DATE OF RECONSIDERATION:_____DENIAL DATE:_____
DATE OF REQUEST FOR HEARING:_____

DID YOU SERVE IN THE MILITARY_____

INCOME YOUR HOUSEHOLD RECEIVES FROM ANY SOURCE, INCLUDING SPOUSE'S :
LIST TYPE & AMOUNT: _____
_____
_____
_____

EDUCATIONAL HISTORY

HIGHEST GRADE COMPLETED_____YEAR_____
GED: YES_____NO_____VOCATIONAL: YES_____NO_____
DESCRIBE TYPE_____

CAN YOU READ? YES_____NO_____NOT WELL_____

CAN YOU WRITE? YES_____NO_____NOT WELL_____
CAN YOU DO MATH? YES_____NO_____NOT WELL_____
MAKE CHANGE_____MANAGE OWN FINANCES_____

EMPLOYMENT HISTORY

DATE LAST WORKED_____OCCUPATION_____
LAST EMPLOYER_____
TIME WITH EMPLOYER_____FROM:_____TO_____
REASON FOR LEAVING LAST EMPLOYER(BE SPECIFIC AND GIVE DETAILS)

_____

_____

MEDICAL LEAVE OF ABSENCE?_____
ANY WORK ATTEMPTS SINCE DISABILITY BEGAN?_____

List all employers for the past 10 years. Start with your last job and work backwards. List type of work you performed over the last 10 years. Answer each question completely.

Dates of Employment:	Name/Address of Employer	Duties Performed at each Job:
FROM:		
TO:		
FROM:		
TO:		
FROM:		
TO:		
FROM:		
TO:		

MEDICAL HISTORY

Please list problems that you claim are bothering you that are causing you to file for Social Security. List which doctor you are seeing for each problem. Begin with your most severe problem.

PROBLEM DOCTOR (Address/Phone) DATES SEEN

1._____

Effect on work?_____

2._____

Effect on work?_____

3._____

Effect on work?_____

4._____

Effect on work?_____

5._____

Effect on work?_____

MEDICATIONS

Please list all medicines that you are currently taking. Include name, milligrams, how many times per day you take them, and the doctor who prescribed each medicine.

Name of Medication	Dosage	Doctor	Side Effects	Date

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,Specify_____

_____

_____

Doctor who prescribed device(s)_____
Do you use any type of home treatment, If so, describe:_____
_____

Have you ever received any physical therapy? _____Dates_____

Name of Physical Therapist_____

Have you ever seen a mental health professional?_____Why_____

List Name, Address, Date(s) seen and reasons_____

_____

_____

Would counseling help you now?_____Why?_____

Have you been to the Bureau of Vocational Rehabilitation?_____If so, list counselor, address, date(s)seen, and reason:
_____
Have you ever been treated by a chiropractor?_____If so, list name and address.
_____

FUNCTIONAL CAPACITY

Check Yes or No to the following items listed. Please describe what type of help is needed.

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/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 at one time without having to stop and rest?_____

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/carry the following weights?

_____ 5 lbs. bag of sugar _____25 pounds
_____ 10 lbs. sack of potatoes _____50 pounds
_____ 20 lbs.

Describe any difficulties you have doing the following:

Bending_____
Stooping_____
Squatting_____
Crawling_____
Climbing Stairs_____
Climbing a Ladder_____
Pushing/Pulling with legs or arms_____
Driving a vehicle_____

TYPICAL DAY

Do you have difficulty sleeping?_____
How many hours do you sleep each night_____Nap?_____How long?_____

What do you do to pass the time each day?_____

Do you hire help(nurse, maid etc)_____Describe_____
Hobbies?_____List them_____
Church?_____List activities/hobbies you gave up due to your medical condition?
_____

Do you leave the house? If so why(shopping, visiting, church, appointments etc.)

Do you have visitors?_____List who and how often_____

ADDITIONAL INFORMATION OR COMMENTS