SOCIAL SECURITY QUESTIONNAIRE

Date:________________

Full Name:____________________________________
First, Middle, Last

Address:______________________________________

City:_________________________State:_________________________Zip:_____________

Home Telephone:_______________ Cell Phone:_______________

Email:____

Date of Birth:__________________ Social Security Number:_____________________

Driver's License Number:_______________________ Height/Weight:________________

Name of Employer:____

Address of
Employer:________________________City:______________State:_________Zip:________

Spouse's Full Name:____

Date of Birth:______________

Referred by (please circle one):

AARP
ATTORNEY
BAR ASSOCIATION
BROKER
BUS BENCH
EMPLOYEE

FINANCIAL ADVISOR
FRIEND
INDEPENDENT FINANCIAL GROUP
LIEN LETTERS
NBI SEMINAR
PRESENT CLIENT

PREPAID LEGAL
PREVIOUS CLIENT
PROVOSTY LAW FIRM
RADIO SHOW
SEMINARS
YELLOW PAGES

OTHER ____

CHILDREN:

Names	Date of Birth
________________________________	________________________
________________________________	________________________
________________________________	________________________
________________________________	________________________

EDUCATION:

What was the last grade completed: ______________

What grades did you received in school: ___________

Do you have any college education: ____Yes ____No

Do you have any trade school education: ____Yes ____No

Do you have any military training: ____Yes ____No

Do you have any problems with reading a newspaper: ____Yes ____No

Do you have any problems with writing a letter: ____Yes ____No

Do you have any problems with doing math: ____Yes ____No

WORK EXPERIENCE IN LAST 15 YEARS:

Employer	Dates	Position	Duties

ACCIDENT OR ONSET OF DISABILITY:

When:______________________________

Where:_____________________________

What
Happened:____

____

MEDICAL TREATMENT:

Name of Doctor (First & Last)	Address	Telephone	Treatment Date(s)	Medical Problem	Which Tests Were Run if any
1.					
2.					
3.					

4.					
5.					

Hospital	**Address**	**Telephone**	**Treatment Dates**	**Medical Problem**	**Which tests were run, if any?**
1.					
2.					
3.					
4.					
5.					

LIST ALL PAIN, DISABILITIES, MEDICAL PROBLEMS AND INJURIES:

Description	How Often	When Start	Effect of Treatment
____________________	___________	___________	___________________
____________________	___________	___________	___________________
____________________	___________	___________	___________________
____________________	___________	___________	___________________
____________________	___________	___________	___________________

1. What effect does disability have on household chores:_________________________________

____

____

2. What effect does disability have on outdoor chores:________________________________

____

____

3. What effect does disability have on hobbies/physical activities:__________________

____

____

4. What effect does disability have on ability to do past work:_____________________

____

____

MEDICATION:

Name of Drug	Dosage	Prescribing Doctor	For what Medical Problem
____________	________	_________	_____________
____________	________	_________	_____________
____________	________	_________	_____________
____________	________	_________	_____________
____________	________	_________	_____________

1. Has your medical problems gotten better, worse or the same since the initial injury?________

____

____

2. What other sources of income do yo have and what is the monthly amount? ______________

____

____

<u>LIST OF DOCUMENTS THAT SHOULD BE BROUGHT IN FOR THE INITIAL OFFICE CONFERENCE:</u>

1. All letters from Social Security Administration

2. All medical reports from hospitals and doctors

3. All decisions from Social Security Administration