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**SOCIAL SECURITY/SSI DISABILITY QUESTIONNAIRE**

NAME \_\_\_\_\_ PHONE \_\_\_\_\_

ADDRESS \_\_\_\_\_

SOCIAL SECURITY NUMBER \_\_\_\_\_

CLAIM FOR \_\_\_\_\_

DATE OF BIRTH \_\_\_\_\_

HEIGHT \_\_\_\_\_ WEIGHT \_\_\_\_\_

DATE YOU MOST RECENTLY APPLIED FOR SOCIAL SECURITY AND/OR SSI  
BENEFITS \_\_\_\_\_ DO YOU HAVE A RECEIPT? \_\_\_\_\_  
PLEASE ATTACH A COPY.

LOCATION OF SOCIAL SECURITY OFFICE WHERE YOU APPLIED  
\_\_\_\_\_

FEEL FREE TO USE THE REVERSE SIDES OF THESE PAGES TO EXPLAIN OR  
COMPLETE ANY ANSWERS THAT REQUIRE ADDITIONAL SPACE.

**I. PERSONAL**

1a. Marital Status (Circle one): Single Married Divorced Separated Widowed

If married, give full name and address of spouse \_\_\_\_\_  
\_\_\_\_\_

1b. If married, what is your spouse's occupation, source of income and amount of income per  
month? \_\_\_\_\_  
\_\_\_\_\_

1c. Spouse's date of birth \_\_\_\_\_

2a. Please give the names, dates of birth and current ages of all your children under the age of 19.

NAME

DATE OF BIRTH

AGE

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**II. EDUCATION**

3a. What is the highest grade you completed in school? \_\_\_\_\_  
When? \_\_\_\_\_

Do you have a GED? \_\_\_\_\_

Were you ever in special education classes in school? \_\_\_\_\_  
Please describe \_\_\_\_\_

3b. Can you read? \_\_\_\_\_ Do you understand the newspaper? \_\_\_\_\_  
Can you write? \_\_\_\_\_

5a. Have you ever kept the financial records in your family? \_\_\_\_\_

5b. Can you take care of a checking account? \_\_\_\_\_

5c. Can you add? \_\_\_\_\_ Subtract? \_\_\_\_\_ Multiply? \_\_\_\_\_ Divide? \_\_\_\_\_

6. Did you ever attend any trade schools or vocational programs?  
\_\_\_\_\_

If yes, what type of program/school was it? \_\_\_\_\_

For what skills? \_\_\_\_\_

Where? \_\_\_\_\_

7. Have you ever attended college? \_\_\_\_\_ If yes, where and when?  
\_\_\_\_\_

8. Are you a veteran? \_\_\_\_\_ If yes, where and when? \_\_\_\_\_

**III. WORK EXPERIENCE**

9a. When did you leave your last job? \_\_\_\_\_

\_\_\_\_\_

9b. Why did you leave your last job? \_\_\_\_\_

\_\_\_\_\_

9c. Could you still perform your last job? \_\_\_\_\_

\_\_\_\_\_

10a. Please list below all the jobs you have had in the past 15 years. Do not worry if you do not know the exact dates.

	<b>Dates of Employment</b>	<b>Name and Location of Employer</b>	<b>Duties Performed</b>	<b>Reasons Why You Left</b>
<b>1</b>				
<b>2</b>				
<b>3</b>				
<b>4</b>				
<b>5</b>				

10b. For each job, describe the physical requirements:

REQUIREMENTS	1st	2nd	3rd	4th	5th
Time Spent Sitting					
Time Spent Standing					
Time Spent Walking					
Weight of objects regularly lifted or pulled					
Machinery Operated					
Hand Tools Used					

**IV. MEDICAL PROBLEMS**

11. When did your disability begin? \_\_\_\_\_

List all physical and mental conditions which caused your disability and how each affects you.

MEDICAL CONDITION	AFFECT ON YOU

12. **THIS IS VERY IMPORTANT**

Please list the names and addresses of all your doctors and all the hospitals at which you have been treated. Include the approximate date that you were treated and the medical condition that you were treated for.

<b>DOCTOR/HOSPITAL</b>	<b>Address and Phone No</b>	<b>Dates of Treatment</b>	<b>Reason for Visits with Doctor</b>

13. Please list all your current medications, how much you take, the side effects (if any) from it, for what problem are you taking it and the physician who prescribed it.

<b>Medication</b>	<b>Amount</b>	<b>Prescribed By</b>	<b>Medical Problem</b>	<b>Side Effect</b>

14. Do you have any problems hearing, seeing, talking or writing? Please describe:

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15. What pain, if any, do you have (including headaches)?

<b>AREA</b>	<b>Is it mild, moderate or severe?</b>	<b>How often &amp; how long does the pain last?</b>	<b>Medication or Treatment</b>

16. Do you, or have you, ever used crutches, cane, wheelchair, brace, walker, TENS unit, house traction, oxygen, or pulmonade machine?

Please describe \_\_\_\_\_  
\_\_\_\_\_

17. Describe the following physical ability since the beginning of your symptoms.

- a. How long can you sit? \_\_\_\_\_
- b. How long can you stand? \_\_\_\_\_
- c. How far can you walk without resting? (blocks) \_\_\_\_\_
- d. How many stairs can you climb without resting? \_\_\_\_\_
- e. How much can you lift? \_\_\_\_\_

18. Describe your ability to bend over and pick up objects.

- a. How far can you bend? \_\_\_\_\_
- b. Maximum weight you can carry? \_\_\_\_\_
- c. Maximum distance you can carry the above weight? \_\_\_\_\_

19. Describe any physical problems with moving limbs, grasping, and using hands.

- a. Ability to fully move arms, wrists, fingers, knees and ankles  
\_\_\_\_\_  
\_\_\_\_\_
- b. Ability to grasp objects \_\_\_\_\_
- c. Ability to do fine manipulation (thread a needle, remove and replace a bolt, etc.)  
\_\_\_\_\_  
\_\_\_\_\_

20. Describe any breathing problems \_\_\_\_\_

21. Do you smoke? \_\_\_\_\_ How often? \_\_\_\_\_

22. Has your appetite been affected by your medical problems?  
\_\_\_\_\_  
\_\_\_\_\_

23. Have you ever seen either a psychologist or psychiatrist? (who, when, where and why)  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

24. Has a doctor ever prescribed a tranquilizer or sedative for you? \_\_\_\_\_  
When and why? \_\_\_\_\_
25. Do you lie down and nap during the day and for how long?  
\_\_\_\_\_
26. How long do you usually sleep without waking? \_\_\_\_\_
27. Do you take medication to help you sleep? \_\_\_\_\_ Type \_\_\_\_\_
28. Do you drink alcoholic beverages and/or use drugs? \_\_\_\_\_  
What and how often? \_\_\_\_\_
29. Have you undergone treatment for alcoholism and/or drug abuse? \_\_\_\_\_  
When and where? \_\_\_\_\_
30. Have you ever refused a surgery or treatment prescribed by a doctor? \_\_\_\_\_  
If yes, why? \_\_\_\_\_
31. Do you have any problems not mentioned previously? \_\_\_\_\_  
If yes, what? \_\_\_\_\_

**V. DAILY ACTIVITIES** (cleaning, shopping, cooking, taking public transportation, paying bills, maintaining a residence, caring appropriately for one's grooming and hygiene, using telephones and directories, using a post office, etc.)

32. Describe how you spend a typical day \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**VI. OTHER CLAIMS**

33. Have you filed other claims as a result of your disabilities?

Veterans Benefits \_\_\_\_\_  
State AFDC (Welfare) Benefits \_\_\_\_\_  
Workers' Compensation \_\_\_\_\_

Disability Pension \_\_\_\_\_  
Personal Injury Suit \_\_\_\_\_  
State Disability Assistance (SDA) \_\_\_\_\_  
State Medicaid \_\_\_\_\_

**VII. PRIOR SOCIAL SECURITY CLAIMS**

34. Have you ever filed for Social Security before? \_\_\_\_\_

35. How many times? \_\_\_\_\_

36. Have you ever had a hearing before an Administrative Law Judge? \_\_\_\_\_

If yes, when and where? \_\_\_\_\_  
\_\_\_\_\_

37. Do you have any documents from your Social Security claim? \_\_\_\_\_  
If yes, please attach.