

Ginsberg Law Offices
Social Security Disability Questionnaire

Personal Information

Today's date: _____ How did you hear about Ginsberg Law? _____

Your Name: _____ Date of Birth: _____

Maiden name/former names: _____

Social Security Number: _____ Marital status: _____

Your address: _____ Apt. #: _____ Rent Own

City: _____ State: _____ Zip: _____ County: _____

Home phone: _____ Work phone: _____ Cell/Beeper: _____

E-Mail address: _____

Name and # of someone who could reach you in an emergency: _____

Marital status:

Married Single Divorced Widowed

If spouse or ex-spouse is deceased what is date of death? _____

Spouse's Name: _____ Date of birth: _____ E-mail: _____

Spouse's maiden/former name: _____

Spouse's social security number: _____ Spouse's work phone: _____

Spouse's home address and home phone (if different from yours): _____

Education:

Last grade completed: _____ Can you read? _____ Can you write? _____

Any special training (military, vocational training, etc.)? _____

Height/Weight

Your height: _____ Your weight: _____

Names and ages of minor children:

Children's names	Age	Date of birth

Names of persons who live with you:

Name	Age	Relationship

Your Household income and support

Spouse's employment: \$ _____ every __ week __ two weeks __ twice a month __ month __ year

Do you own a bank account: _____ Name of bank: _____ Acct #: _____

How do you get by every month? _____

Worker's compensation:

Does your disability arise in whole or in part from an on-the-job injury? _____

If so, please describe what happened: _____

Weekly benefit: \$ _____ Benefits started on: _____

Workers' comp insurance company: _____

Who is your workers' comp lawyer?: _____

Amount of settlement or expected date of settlement: _____

Other monthly income

Type of benefits	Monthly amount	Beginning/ending dates
VA		
AFDC		
Food Stamps		
Unemployment		
General assistance		
Other (describe)		

Assets (things you own worth more than \$2000):

Describe item	Value	Comments

Social Security Claim Information:

1. When did you file your application for Social Security benefits? _____
2. Had you ever filed for benefits before?

Date/year of filing	Denied or approved?	When were you last denied

3. On your current application, what date did you claim as the date you became unable to work?

4. Have you received a denial notice on this current claim? _____
5. What date did your receive the denial notice? _____
 - a. Please attach a copy of your last denial notice – if you have it..

Work History

1. Are you currently working full or part time? _____
2. If so, what type of work are you doing? _____
3. Have you tried to work since the onset date of your disability? _____
 - a. If so, where did you try to work? _____

4. Have you looked for work since the onset of your disability? _____
5. Is there any work you think you could do? _____
 - a. If so, please describe the work you think you could do: _____

6. Before you left your last job, did your medical problems require you to make any changes in the hours of work, the way you worked, your job duties, absences, etc.? If so, what were there changes? _____

Your Past Jobs

Please list your work for the last 15 years. List most recent job first and then your next most recent job, etc.

Employer				
Address		City:	ST	Zip
Job title				
Reason for leaving				
Job description				
Dates of employment				

Employer				
Address		City:	ST	Zip
Job title				
Reason for leaving				
Job description				
Dates of employment				

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Address		City:	ST	Zip
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Reason for leaving				
Job description				
Dates of employment				

MEDICAL CONDITIONS:

Please list your health problems which make you unable to work (list them in order of severity):

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

MEDICAL TREATMENT:

Are you presently under doctor's care: Yes _____ No

Is there one doctor who knows your case the best and would be willing to help us prove that you are unable to work? Which doctor?

Please list the doctors that have treated you:

Doctor		Specialty		
Address		City:	ST	Zip
First seen		Last seen		
Phone #		Will this doctor help you?		
Type of treatment				
How frequently do you see this doctor?				

Doctor		Specialty		
Address		City:	ST	Zip
First seen		Last seen		
Phone #		Will this doctor help you?		
Type of treatment				
How frequently do you see this doctor?				

Doctor		Specialty		
Address		City:	ST	Zip
First seen		Last seen		
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Address			City:	ST	Zip
First seen			Last seen		
Phone #			Will this doctor help you?		
Type of treatment					
How frequently do you see this doctor?					

Doctor			Specialty		
Address			City:	ST	Zip
First seen			Last seen		
Phone #			Will this doctor help you?		
Type of treatment					
How frequently do you see this doctor?					

Hospitals

Hospital			Specialty		
Address			City:	ST	Zip
First seen			Last seen		
Phone #			Admitting doctor		
Type of treatment					
Dates of treatment					

Hospital			Specialty		
Address			City:	ST	Zip
First seen			Last seen		
Phone #			Admitting doctor		
Type of treatment					

OVER-THE-COUNTER-MEDICATIONS

Name of Medicine	Dosage & frequency	Medical condition

Financial stress:

As a result of your being unable to work, do you experience stress, depression or other mental aggravation?

If yes, please describe: _____

How much do you owe in total? _____