DATE: _____________________ **Referred By:** ____________________________

Winter & Rhoden

Attorney at Law

Social Security Initial Interview Questionnaire

Your Full Name: _____________________________________ SSN: ___________________

Address: _____________________________________ City: ____________ Zip:________

Telephone: (Home) _______________ (Cell)________________ Place of Birth: ____________

Date of Birth: ________ Age: ____ Education: _______________________

Mother's Maiden Name: _______________________

Date of Filing Initial Application For Soc. Sec. Benefits: __________________
If you have applied:

1. At Which office did you apply?____
2. Have you received a denial?______________ If yes, date: ___________________
3. Did you appeal? ________________ If yes, date: _________________

Have you ever previously applied for Soc. Sec. benefits: _________ If yes, please complete:

Date of Filing: ______________________
What Type of Benefits: Disability ________; SSI ________; BOTH ________
Have you been turned down on your initial application: [ ] yes [ ] no Date: _______
Have you applied for reconsideration: [ ] yes [ ] no Date: ________
Have you requested a hearing before an ALJ: [ ] yes [ ] no Date: ________
In your initial application, what date did you give as the onset of your disability: _______
When was the last date you worked: _______________
Have your Soc. Sec. Benefits been terminated: [ ] yes [ ] no Date: ________

Spouse's Name: ____
.

Do you have any dependent children? ____________________

Name: _________________________ Age: _______ DOB: _____________
Name: _________________________ Age: _______ DOB: _____________
Name: _________________________ Age: _______ DOB: _____________

Did you serve in the military: _____ Branch: ____________ Date of discharge: _____________

Have you received any special vocational training: If yes, then state type of training and from what school or branch of the military service:____

____

Do you have the following capacities at the present time:

Seeing [ ] yes [ ] no Limitations: _________________________

Hearing [ ] yes [ ] no Limitations: ____________________________
Speaking [ ] yes [ ] no Limitations: ____________________________
Understanding & carrying out simple instructions [ ] yes [ ] no
Use of Judgment [ ] yes [ ] no
Responding to supervision at work positively [ ] yes [ ] no
Dealing with changes in a routine work setting [ ] yes [ ] no

Can you perform the following activities on a regular basis during an 8 hour work day:

walking [ ] yes [ ] no Limitations: ____________________________
standing [ ] yes [ ] no Limitations: ____________________________
sitting [ ] yes [ ] no Limitations: ____________________________
lifting [ ] yes [ ] no Limitations: ____________________________
pushing [ ] yes [ ] no Limitations: ____________________________
pulling [ ] yes [ ] no Limitations: ____________________________
reaching [ ] yes [ ] no Limitations: ____________________________
carrying [ ] yes [ ] no Limitations: ____________________________
handling [ ] yes [ ] no Limitations: ____________________________
bending [ ] yes [ ] no Limitations: ____________________________
squatting [ ] yes [ ] no Limitations: ____________________________
crawling [ ] yes [ ] no Limitations: ____________________________
climbing [ ] yes [ ] no Limitations: ____________________________
push & pull arm controls [ ] yes [ ] no Limitations: __________________________
push & pull leg controls [ ] yes [ ] no Limitations: __________________________

What activities can you perform now in spite of your disability:______________________________

____

What hobbies do you enjoy: ____

DAILY ACTIVITIES

Are your home duties/chores of daily living limited or restricted due to your condition? _____
Are you presently able to: Drive a car [ ] yes [ ] no Short distances? __________

Dress yourself [ ] yes [ ] no With help? _____
Cook for yourself [ ] yes [ ] no With help? _____
Do dusting [ ] yes [ ] no With help? _____
Do vacuuming [ ] yes [ ] no With help? _____
Use Washer & Dryer [ ] yes [ ] no With help? _____
Wash floor, windows [ ] yes [ ] no With help? _____
Shop for groceries [ ] yes [ ] no With help? _____
Put out trash [ ] yes [ ] no With help? _____
Mow the lawn [ ] yes [ ] no With help? _____
Wash dishes [ ] yes [ ] no With help? _____
Climb stairs [ ] yes [ ] no With help? _____
Make beds [ ] yes [ ] no With help? _____
Walk [ ] yes [ ] no With help? _____

Lift [ ] yes [ ] no With help? _____
Sit [ ] yes [ ] no With help? _____

Do you participate in any sports/hobbies? (Specify) ____

____

Do you take care of any children? (specify) ____

____

Did you have any hired help to assist you? (nurses, homemakers, etc.) ________

AVERAGE DAY: In a typical day, what do you do between the hours of (include sleep/recline):
6:00 a.m. – 11:00 a.m. ____

____

11:00 a.m. – 3:00 p.m. ____

____

3:00 p.m. – 11:00 p.m. ____

____

After 11:00 p.m. ____

____

Do you or your spouse receive any of the following?

Worker's Compensation [ ] yes [ ] no Amount: ________
Long-term Disability under an insurance plan [ ] yes [ ] no Amount: ________
Retirement or pension [ ] yes [ ] no Amount: ________
VA benefits or pension [ ] yes [ ] no Amount: ________
Unemployment compensation [ ] yes [ ] no Amount: ________
Food stamps [ ] yes [ ] no Amount: ________
Any other Social Security ________ If so, please state what type: ________________

Will you agree to have us refer you to medical specialists and will you agree to pay the specialist's bill if a referral is made: Yes ________ No ________

Will you agree to have us refer you to a vocational expert if we determine that such an expert is necessary in your case: Yes ________ No ________

EMPLOYMENT OVERVIEW

Last Day you worked: ____________________

Have you worked at all since the onset of your disability: Yes ________ No ________
Have you worked at all since you filed for Soc. Sec. Benefits: Yes ________ No ________
If so, please give the dates worked and the name and address of the employer:
Dates: From: ________ To: ________

Name and Address: ____

Job Description: ____

Previous Employment: *Must go back 15 years – use back page if needed*

1. Employer: ______________________________________ Phone #: ________________

Address: ____ City:_____________ Zip:________

Job Description:____

Length of Employment: ___________

2. Employer: ______________________________________ Phone #: ________________

Address: ____ City:_____________ Zip:________

Job Description:____

Length of Employment: ___________

3. Employer: ______________________________________ Phone #: ________________

Address: ____ City:_____________ Zip:________

Job Description:____

Length of Employment: ___________

4. Employer: ______________________________________ Phone #: ________________

Address: ____ City:_____________ Zip:________

Job Description:____

Length of Employment: ___________

MEDICAL OVERVIEW

Has your disability existed for a period of 12 months, or have you been advised by a physician that your disability is expected to last for a period of 12 months or longer: Yes ____ No _____

Have you ever worked in a coal mine, steel mill, as a welder, or with asbestos? If so, give dates and name of employer:____

____

Describe in detail the disabilities you are claiming since the allege onset of disability:

____

____

____

____

____

____

Please give information of physicians/hospitals who have or are now treating you:

1. **Name:** ____

Address: ____ City: _____________ Zip:_________

Telephone:________________ Fax: ___________________ Next Appt: _____________________

1st Visit: ___________ Last Visit: _______________ How Often Seen: ______________

Condition: ____

Treatment Rec'd: ____

Restrictions: ____

2. **Name:** ____

Address: ____ City: _____________ Zip:_________

Telephone:________________ Fax: ___________________ Next Appt: _____________________

1st Visit: ___________ Last Visit: _______________ How Often Seen: ______________

Condition: ____

Treatment Rec'd: ____

Restrictions: ____

3. Name: ____

Address: ______________________________________ City: ____________ Zip:________

Telephone:_______________ Fax: __________________ Next Appt: ____________________

1st Visit: __________ Last Visit: ______________ How Often Seen: _____________

Condition: ____

Treatment Rec'd: ____

Restrictions: ____

4. **Name:** ____

Address: ______________________________________ City: ____________ Zip:________

Telephone:_______________ Fax: __________________ Next Appt: ____________________

1st Visit: __________ Last Visit: ______________ How Often Seen: _____________

Condition: ____

Treatment Rec'd: ____

Restrictions: ____

5. Name: ____

Address: ______________________________________ City: ____________ Zip:________

Telephone:_______________ Fax: __________________ Next Appt: ____________________

1st Visit: __________ Last Visit: ______________ How Often Seen: _____________

Condition: ____

Treatment Rec'd: ____

Restrictions: ____

6. Name: ____

Address: ____________________________________ City: ____________ Zip:________

Telephone:_______________ Fax: __________________ Next Appt: ____________________

1st Visit: __________ Last Visit: ______________ How Often Seen: _____________

Condition: ____

Treatment Rec'd: ____

Restrictions: ____

7. Name:____

Address: ____________________________________ City: ____________ Zip:________

Telephone:_______________ Fax: __________________ Next Appt: ____________________

1st Visit: __________ Last Visit: ______________ How Often Seen: _____________

Condition: ____

Treatment Rec'd: ____

Restrictions: ____

8. Name: ____

Address: ____________________________________ City: ____________ Zip:________

Telephone:_______________ Fax: __________________ Next Appt: ____________________

1st Visit: __________ Last Visit: ______________ How Often Seen: _____________

Condition: ____

Treatment Rec'd: ____

Restrictions: ____

What Medications are you taking, prescribed by whom, and for what conditions?

Medication	Prescribing Physician	Condition

Have you ever been treated for any mental or psychiatric condition: Yes _____ No _____
If yes, complete the following:

Date: __________ Hospital/physician:_________________________ Condition: ____________

Date: __________ Hospital/physician:_________________________ Condition: ____________

Date: __________ Hospital/physician:_________________________ Condition: ____________

Have you ever been addicted to the following: Alcohol _____ Drugs _____ Cigarettes _____