

**GINSBERG LAW OFFICES, P.C.**  
**SOCIAL SECURITY DISABILITY QUESTIONNAIRE**

Date of intake _____ Stage at intake _____
Date current application filed _____ Interviewed by _____
DIB SSI Other _____ DLI: _____
W/C case (Y/N): _____

For office use only

**Personal Information**

Your full name: \_\_\_\_\_ SS# \_\_\_\_\_

a/k/a (other names used): \_\_\_\_\_

Address: Street \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Mailing Address: (if different) \_\_\_\_\_

-  
Home Phone \_\_\_\_\_ Pager \_\_\_\_\_ E-mail: \_\_\_\_\_

If we had to reach you in an emergency, who should we call?

Emergency name \_\_\_\_\_ Phone #: \_\_\_\_\_

-  
Emergency name #2: \_\_\_\_\_ Phone #: \_\_\_\_\_

Birth date: \_\_\_\_\_ Age: \_\_\_\_\_ US Citizen Y\_\_ N\_\_ Have you ever served in the military: Y\_\_ N\_\_

Marital Status: \_\_\_ Married \_\_\_ yrs. \_\_\_ Single \_\_\_ Divorced \_\_\_ Widowed, date of spouses death \_\_\_ \ \_\_\_ \ \_\_\_

Spouse: \_\_\_\_\_ SS# \_\_\_\_\_ Spouse's date of birth \_\_\_\_\_

-  
**Education:**

Last grade completed: \_\_\_\_\_ Can you read? \_\_\_\_\_ Can you write? \_\_\_\_\_

**Height/Weight**

Your height: \_\_\_\_\_ Your weight: \_\_\_\_\_

Names and ages of minor children:

1. \_\_\_\_\_ 2. \_\_\_\_\_

3. \_\_\_\_\_ 4. \_\_\_\_\_

5. \_\_\_\_\_ 6. \_\_\_\_\_

Names of persons who live with you:

Relationship

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_

**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 #: \_\_\_\_\_

Worker's compensation:

Weekly benefit: \$ \_\_\_\_\_ Benefits commenced on: \_\_\_\_\_

WC Carrier: \_\_\_\_\_ WC Attorney: \_\_\_\_\_

Amount of settlement or expected date of settlement: \_\_\_\_\_

VA Benefits: \$ \_\_\_\_\_ every \_\_ week \_\_ month

AFDC Benefits: \$ \_\_\_\_\_ every month

Food Stamps: \$ \_\_\_\_\_ every month

Unemployment Benefits: \$ \_\_\_\_\_ every \_\_ week \_\_ two weeks \_\_ month \_\_ year \_\_\_\_\_

General Assistance: \$ \_\_\_\_\_ every month

Other Benefits/Income from \_\_\_\_\_ every \_\_ week \_\_ two weeks \_\_ month \_\_ year \_\_\_\_\_

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

Has a friend or family member ever helped you with your rent? \_\_\_\_\_ If so, who and how often? \_\_\_\_\_  
\_\_\_\_\_

Have you ever had to stay with a friend or relative because of lack of income? \_\_\_\_\_  
If so, who and how often? \_\_\_\_\_  
\_\_\_\_\_

**Social Security Claim Information:**

1. On what date did you apply for social security disability and/or SSI benefits: \_\_\_\_\_

2. In your application, what date did you state as the date you became unable to work? \_\_\_\_\_

3. Did you ever file for Social Security disability before? \_\_\_\_\_

If so, when?: \_\_\_\_\_

4. When did you last receive a denial letter from Social Security \_\_\_\_\_

**Work History**

1. Are you currently working? \_\_\_\_\_ If so, what type of work are you doing? \_\_\_\_\_

---

-  
2. Have you tried to work since the onset date of your disability? \_\_\_\_\_ If so, where did you try to work? \_\_\_\_\_

-  
3. Have you looked for work since the onset of your disability? \_\_\_\_\_

4. Is there any work you think you could do? \_\_\_\_\_ If so, please describe the work you think you could do: \_\_\_\_\_

—  
5. 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? \_\_\_\_\_

---

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

1. Last Employer: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Job Title: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
Brief Description: \_\_\_\_\_

2. Last Employer: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Job Title: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
Brief Description: \_\_\_\_\_

3. Last Employer: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Job Title: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
Brief Description: \_\_\_\_\_

4. Last Employer: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_

Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Job Title: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
Brief Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

5. Last Employer: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Job Title: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
Brief Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

6. Last Employer: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Job Title: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
Brief Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

7. Last Employer: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Job Title: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
Brief Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

8. Last Employer: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Job Title: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
Brief Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

9. Last Employer: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Job Title: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
Brief Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

10. Last Employer: \_\_\_\_\_ Dates: \_\_\_\_\_ to \_\_\_\_\_  
Employer's Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code \_\_\_\_\_  
Job Title: \_\_\_\_\_ Reason for leaving: \_\_\_\_\_  
Brief Description: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**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:

1. Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Office: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
First Seen: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Next Appt. \_\_\_\_\_

2. Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Office: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
First Seen: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Next Appt. \_\_\_\_\_

3. Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Office: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
First Seen: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Next Appt. \_\_\_\_\_

4. Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Office: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
First Seen: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Next Appt. \_\_\_\_\_

5. Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Office: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
First Seen: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Next Appt. \_\_\_\_\_

6. Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Office: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
First Seen: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Next Appt. \_\_\_\_\_

7. Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Office: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
First Seen: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Next Appt. \_\_\_\_\_

8. Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Office: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
First Seen: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Next Appt. \_\_\_\_\_

9. Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Office: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
First Seen: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Next Appt. \_\_\_\_\_

10. Doctor: \_\_\_\_\_ Specialty: \_\_\_\_\_  
Office: \_\_\_\_\_ Phone: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
First Seen: \_\_\_\_\_ Last Seen: \_\_\_\_\_ Next Appt. \_\_\_\_\_

Hospitals

Please list all of the hospitals that have treated you for conditions related to your current disability:

1. Hospital: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Dates: \_\_\_\_\_ to \_\_\_\_\_ \_\_\_ In Patient \_\_\_ Out-Patient \_\_\_ Emergency Room  
Purpose: \_\_\_\_\_  
\_\_\_\_\_

2. Hospital: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_  
Dates: \_\_\_\_\_ to \_\_\_\_\_ \_\_\_ In Patient \_\_\_ Out-Patient \_\_\_ Emergency Room  
Purpose: \_\_\_\_\_  
\_\_\_\_\_

3. Hospital: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Dates: \_\_\_\_\_ to \_\_\_\_\_ \_\_\_ In Patient \_\_\_ Out-Patient \_\_\_ Emergency Room  
Purpose: \_\_\_\_\_  
\_\_\_\_\_

4. Hospital: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_  
Dates: \_\_\_\_\_ to \_\_\_\_\_ \_\_\_ In Patient \_\_\_ Out-Patient \_\_\_ Emergency Room  
Purpose: \_\_\_\_\_  
\_\_\_\_\_

5.  
Hospital: \_\_\_\_\_ Doctor: \_\_\_\_\_  
Address: \_\_\_\_\_

City: \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Dates: \_\_\_\_\_ to \_\_\_\_\_  In Patient  Out-Patient  Emergency Room

Purpose: \_\_\_\_\_

---

**MEDICATIONS:**

Please list all of the medications you are presently taking:

	<u>Drug</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Condition</u>	<u>Prescribing Doctor</u>
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____
6.	_____	_____	_____	_____	_____
7.	_____	_____	_____	_____	_____
8.	_____	_____	_____	_____	_____
9.	_____	_____	_____	_____	_____
10.	_____	_____	_____	_____	_____

**OVER-THE-COUNTER-MEDICATIONS**

	<u>Drug</u>	<u>Dosage</u>	<u>Frequency</u>	<u>Condition</u>
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____