PLACHTA, MURPHY & ASSOCIATES
attorneys and counselors at law

SOCIAL SECURITY INTERVIEW FORM

CLIENT INFORMATION

Name: _____ Date: _____

Address: _____

_____

Telephone: Home: _____ Work: _____ Other: _____

Email: _____ SS#: _____

Date of Birth: _____ Place of Birth: _____

Marital Status: Married: ☐ Single: ☐

Spouse's Name: _____

Dependent Children:

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

Name: _____ Age: _____

INCOME:

Do you have any income? (i.e. unemployment benefits, workman's compensation, short-term disability, financial aid or food stamps, benefits from employer, etc.)

Yes: ☐ No: ☐

If yes, please provide the amount and source of your income: _____

_____

_____

If no income, how are you financially supported? _____

_____

HEALTH INSURANCE:

Do you have health insurance? Yes: ☐ No: ☐

If yes, please provide the name of your insurance carrier? _____

If not, how are you paying for medical treatment/expenses? _____

OTHER INFORMATION:

Do you use alcohol and/or recreational drugs (i.e. marijuana or cocaine)? Yes: ☐ No: ☐

If yes, how often: _____

Have you ever been convicted of a crime? Yes: ☐ No: ☐

If yes, please describe: _____

DISABILITY ONSET & IMPAIRMENTS:

What did Social Security use as your **date of onset**? (this is usually when you stopped working because of your impairments) _____

What is your **Primary Disability** (i.e. the reason for filing for Social Security Benefits)?

Please list all major and minor impairments: _____

_____

_____

Status of Impairment(s) since filing for disability (better or worse): _____

_____

How does your disability prevent you from working or would prevent you from doing other jobs?

Please describe: _____

_____

_____

Pain:

Description: _____

_____

Frequency: _____

Duration: _____

MEDICAL TREATMENT HISTORY:

Primary Care Provider(s):

Name: _____

Address: _____

_____

Phone #: _____

Date of 1st Visit: _____ Date of Next Appointment: _____

Name: _____

Address: _____

_____

Phone #: _____

Date of 1st Visit: _____ Date of Next Appointment: _____

Other Medical Sources: (i.e. other doctors, hospitals, clinics, etc.)

Please describe: _____

_____

Surgery(ies):

Yes: ☐ No: ☐

If yes, please provide the following information:

Name of Hospital: _____ Name of Hospital: _____

Name of Doctor: _____ Name of Doctor: _____

Type of Surgery: _____ Type of Surgery: _____

Date(s): _____ Date(s): _____

Length of Stay: _____ Length of Stay: _____

Have you had other **Medical Tests, Treatment, or Restrictions** since filing for Disability?

Yes: ☐ No: ☐

If yes, please describe: _____

_____

Current Medications:

Name: _____ Name: _____

Dosage: _____ Dosage: _____

Side Effects: _____ Side Effects: _____

Name: _____ Name: _____

Dosage: _____ Dosage: _____

Side Effects: _____ Side Effects: _____

Past Medications:

Name: _____ Name: _____

Dosage: _____ Dosage: _____

Why Terminated: _____ Why Terminated: _____

Height: _____ Weight: _____ Usual Weight: _____

Comments on weight loss (if any): _____

EDUCATION:

Last grade completed: _____ Last year attended: _____

Any technical or special skill training: _____

EMPLOYMENT HISTORY/WORK EXPERIENCE:

****This is VERY IMPORTANT: Please list employment for the last fifteen (15) years, and describe the reason for termination or resignation****

#	Employer:	Job Title:	Describe Daily Activities:	Date Started:	Date Ended:
1					
2					
3					
4					
5					
6					

Please describe the **reason for leaving** any of the above jobs:

Job: _____ Reason for Leaving: _____

_____

Job: _____ Reason for Leaving: _____

_____

Job: _____ Reason for Leaving: _____

_____

In any of the above jobs, did you use **machines, tools, or equipment**? Yes: ☐ No: ☐

If yes, which ones: _____

_____

In any of the above jobs, did you use **technical knowledge or skills**? Yes: ☐ No: ☐

If yes, which ones: _____

_____

In any of the above jobs, did you do any **writing, reports, or similar duties**? Yes: ☐ No: ☐

If yes, which ones: _____

_____

Unemployment Benefits:

In the last five (5) years, did you apply for unemployment benefits? Yes: ☐ No: ☐

If yes, did you state that you were willing and able to work full-time on the application?

Yes: ☐ No: ☐

Did you work after you filed for Social Security Disability? Yes: ☐ No: ☐

If yes, please describe: _____

_____

<u>RELATIONSHIP BETWEEN IMPAIRMENT & WORK</u>:

Did you experience any adverse working conditions (i.e. heat, cold, dust, noise, stress, etc.):

Yes: ☐ No: ☐

If yes, please describe: _____

_____

Effects of Impairment on Work (i.e. speed, danger, quality of work, rest periods, etc.):

Yes: ☐ No: ☐

If yes, please describe: _____

_____

PSYCHOLOGICAL FACTOR: (i.e. depression, anxiety, panic attacks, etc.)

Do you experience depression, anxiety, panic attacks, etc.? Yes: ☐ No: ☐

If yes, please describe: _____

_____

Do you have any Friends, Family, or Co-Workers that would comment on your disability, job performance, home activities, etc.? Yes: ☐ No: ☐

If yes, please provide their names: _____

_____

EFFECT OF IMPAIRMENT ON ACTIVITIES OF DAILY LIVING (ALD'S):

Has your impairment changed ability to work? Yes: ☐ No: ☐

If yes, you will be asked to provide Social Security with additional information, which you may receive from them in the mail within a reasonable time after submitting your application.

Does you impairment effect your everyday routine activities? Yes: ☐ No: ☐

If yes, please describe: _____

_____

_____

Does you impairment effect your social and recreational activities or hobbies (past vs. present)?

Yes: ☐ No: ☐

If yes, please describe: _____

_____

_____

Please provide any additional comments:

_____

_____

_____

_____

_____

Did we forget anything that might be relevant? Yes: ☐ No: ☐

If yes, please describe: _____

_____

_____

Thank you for completing this confidential questionnaire. It is for our use only and is informal. It helps us to get an overall "feel" of how your impairments affect your overall lifestyle and how we can best build and present your case for benefits.

After completing this confidential questionnaire, please provide a copy to our office by mail, fax (616) 458-2410, or email to rcross@pmalawpc.com.