SOCIAL SECURITY DISABILITY INTERVIEW FORM
GENERAL INFORMATION

Date of Interview__________________________________ Social Security Office_____________________

Full Name ____Age _______

Date of Birth___________________________ Social Security Number______________________________

Maiden Name_________________________________ Mother's Maiden Name ___________ _____________

US Citizen: Yes ☐ No ☐ Place of Birth ____

Mailing Address_______________________________________ County______________________________

Street Address____

City____________________________________ State_________________ Zip Code________________

Telephone # ____

MARITAL STATUS ____________________________ Number of Children________________________

Spouse Name__________________________________ Social Security Number______________________

Date of Birth _________________________________ Place of Birth_____________________________

Place & Date of Marriage____

Spouse's Employer____ _____________ Wage_____________

Is Spouse blind or disabled Yes ☐ No ☐

CHILDREN UNDER 18 YEARS OF AGE

Name	Date of Birth	Place of Birth	SS#

1. ____
2. ____
3. ____
4. ____
5. ____

First Applied for Disability ____

Status of Application_______________________________ Onset date of Disability_____________________

Result of Accident of WC Yes ☐ No ☐

Height __________ Weight_________ Sex_________

WORK HISTORY AND TRAINING

What grade completed at school ____

Any Special degrees or training ____

Military Service: From ______________________ To ______________________

Special Training ____

PAST JOBS

(all jobs since you started working from most recent to first job)

DATES	TITLE	TYPE OF WORK	WORK DONE	DAYS PER WK	SALARY
1.					
2.					
3.					
4.					
5.					
6.					
7.					
8.					
9.					
10.					

What is your usual job, trade or occupation for the last 15 years?____

____

What are your duties of your usual job?____

____

Did job require use of machines, tools or equipment? If yes, specify.____

____

Did you require technical knowledge or special skills? If yes, specify. ____

____

Did your job require supervisory responsibilities? ____

Would you classify your job as light or heavy? ____

How many hours were spent Walking ______________ Standing _____________ Sitting ___________ in a usual day.

Was there any lifting or carrying? Yes _______ No ________

What was lifted ____________________ How heavy _________________ How Often ________________________

Are you presently able to perform the duties of your usual job? Yes ___ No ______ Why not? _________________

____

____

Have you worked at all since the onset of your injury or condition? ____

____

____

Have you looked for work? ____

____

____

Is there any work you think you could do? ____

____

____

MEDICAL TREATMENT

What injuries, diseases, or conditions are you suffering from? ____

____

____

____

Which one is the major cause of your disability? ____

____

____

When did your condition(s) first start bothering you? (date) ____

When did your condition(s) prevent you from working? (date) ______________________________________

What parts of your body are affected by your condition? ____

TREATING PHYSICIANS

1. Name ____________________________________ Specialty ___________________________________

Address ____

Phone Number _______________________ Date you first saw _______________ Last saw ______________

Condition treated for ____

What treatment did you receive ____

Prosthesis prescribed (specify) ____

Medications prescribed (specify) ____

____

What did doctor tell you about your condition? ____

____

Restrictions? ____

____

Times visited Doctor ____________________________ Future Appts. _____________________________

2. Name ____________________________________ Specialty ___________________________________

Address ____

Phone Number _______________________ Date you first saw _______________ Last saw ______________

Condition treated for ____

What treatment did you receive ____

Prosthesis prescribed (specify) ____

Medications prescribed (specify) ____

____

What did doctor tell you about your condition? ____

____

Restrictions? ____

____

Times visited Doctor ___________________________ Future Appts. _____________________________

3. Name __________________________________ Specialty _________________________________

Address ____

Phone Number _____________________ Date you first saw ______________ Last saw ______________

Condition treated for ____

What treatment did you receive ____

Prosthesis prescribed (specify) ____

Medications prescribed (specify) ____

____

What did doctor tell you about your condition? ____

____

Restrictions? ____

____

Times visited Doctor ___________________________ Future Appts. ____________________________

MEDICATIONS

Drug Name	Dosage	Frequency	Doctor Prescribing	Effect on Client

Are you taking any over the counter medications? ____

____

____

____

HOSPITALIZATIONS

If you have been hospitalized for your condition, please specify below, listing latest hospitalization first.

1. Hospital Name ____________________________ Address ____

Dates: Outpatient __________________________________ Inpatient- From __________ to ________________

Treatment Received ____

Treating Doctor at Hospital ___________________________ Who recommended _________________________

Any surgical or other procedures done ____

Who paid bill ____

2. Hospital Name ____________________________ Address ____

Dates: Outpatient __________________________________ Inpatient- From __________ to ________________

Treatment Received ____

Treating Doctor at Hospital ___________________________ Who recommended _________________________

Any surgical or other procedures done ____

Who paid bill ____

3. Hospital Name ____________________________ Address ____

Dates: Outpatient __________________________________ Inpatient- From __________ to ________________

Treatment Received ____

Treating Doctor at Hospital ___________________________ Who recommended _________________________

Any surgical or other procedures done ____

Who paid bill ____

AVERAGE DAY

In your typical day, what do you do between the hours of:

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. ____

____

____

What activities are you unable to do now that you used to do? ______________________________

____

____

DAILY ACTIVITIES

Are your hone duties or chores of daily living limited or restricted due to your condition? Yes _____ No _____

Are you presently able to: (YES) (NO)

Drive a car ______________________________ Short Distances?

Dress Yourself ______________________________ With help?

Cook for yourself ______________________________ With help?

Do dusting ______________________________ With help?

Do vacuuming ______________________________ With help?

Use Washer and Dryer ______________________________ With help?

Wash floors and Windows ______________________________ With help?

Shop for groceries ____ With help?

Put out trash ____ With help?

Mow the lawn ____ With help?

Wash dishes ____ With help?

Climb Stairs ____ How many?

Make beds ____ With help?

Walk ____ How far?

Lift ____ How Much? ______ How often? ____

Sit ____ How long without getting up? _______

Do you have any hobbies? (specify) ____

Do you participate in any sports? ____

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

Do you have any hired help to assist you? ____

FINANCIAL INFORMATION

Please indicate income or assets in your spouse's name. ____

____

Have you earned any money in the last 12 months? (Breakdown Quarterly) ______________________________

____

Name and Address of employer ____

____

Have you been self-employed during the last 24 months? Yes _______ No ______

Type of Business ____

Last Year's Gross _______________________________ Net ____

This Year's Gross _______________________________ Net ____

Do you or your spouse receive any of the following?

	Claimant	*Spouse*
Social Security		
Unemployment		
Workman's Compensation		
Private Pension		
State or Local Pension		
Federal Civil Service Annuity		
Railroad Retirement Benefits		
Black lung Benefits		
Veteran's Administration Pension		
Insurance Annuity or Proceeds		
Rents, Dividends, Interest of Royalties		
Cash Support		
Assistance Based on Need (such as food stamps)		
Other		
Total Income		