SOCIAL SECURITY DISABILITY INTAKE FORM

1. Name:_____

2. Social Security Number: _____ D/O/B _____

   Age today: _____

3. Mailing Address:
   _____
   _____
   _____

4. Phone numbers: _____

5. Alternate Contact Name: _____

   Phone number: _____

   Alternate Address:

   _____

   _____

6. Education: _____

7. Mother's Maiden Name:_____

8. Your State of birth:_____

9. Who do you live with? _____

10. If you stopped working, what date did you stop? _____

11. What was the last date you worked for pay? _____

12. If you stopped working, why did you stop working? _____

13. What physical or mental conditions (or both) do you believe prevent you from working?

    _____

    _____

_____

_____

14. Have you applied for/are you eligible for VA benefits? _____

15. Did (or do) you collect unemployment benefits? YES NO

16. Did (or do) collect private disability insurance benefits? YES NO

17. What sources of income do you currently have?

_____

_____

_____

18. Do you receive state assistance such as food stamps or Medicaid? YES NO

19. Do any of your doctors say you should be on disability? YES NO

If yes, then who? _____

20. Please list your medical professionals (including psychiatric professionals and facilities) For last 10 years:

Name	City	Last Treated

21. List the names of any facilities that took MRIs, CAT scans, or X-Rays related to your impairments:

_____

_____

_____

_____

22. Please list your current medications:

_____

_____

_____

_____

_____

_____

_____

_____

_____

23. What side effects do your medications cause?

_____

_____

_____

24. Do you have any history of any of the following:

a. Substance abuse: Y OR N

b. Alcohol abuse: Y OR N

c. Marijuana use: Y OR N

d. Nicotine addiction: Y OR N

e. Criminal history including felony (or felonies): Y OR N

i. If yes, please list your felony or felonies and prison time served:

_____

_____

_____

f. Criminal history including misdemeanor(s): Y OR N

i. If yes, please list your misdemeanor(s) and sentence(s):

_____

_____

_____

g. If you answered "yes" to (e) or (f), were you on probation or parole? Y OR N

h. If so, when did that probation or parole end? _____

25. Are you able to perform any of the following?

1. Cooking: Y OR N

2. Cleaning: Y OR N

3. Laundry: Y OR N

4. Dishes: Y OR N

5. Household repairs: Y OR N

6. Caring for pets: Y OR N

7. Caring for children: Y OR N

8. Mowing the lawn: Y OR N

9. Shoveling snow: Y OR N

10. Drive a car: Y OR N

11. Use a computer: Y OR N

12. Climb stairs: Y OR N

13. Go to the bank: Y OR N

14. Grocery shopping: Y OR N

15. Follow written directions: Y OR N

16. Follow spoken directions: Y OR N

17. Your own personal care, hygiene, and grooming: Y OR N

18. Vehicular repairs: Y OR N

26. Do you have good and bad days? Y OR N

a. Number of good days per month: _____

b. Number of bad days per month: _____

c. What is a good day like?

_____

_____

_____

d. What can you do on a good day?

_____

_____

_____

e. What is a bad day like?

_____

_____

_____

f. What can you do on a bad day?

_____

_____

_____

27. Are you limited in your ability to:

a.	Sit:	Y	OR	N
b.	Stand:	Y	OR	N
c.	Walk:	Y	OR	N
d.	Lift:	Y	OR	N
e.	Carry:	Y	OR	N
f.	Bend:	Y	OR	N
g.	Stoop:	Y	OR	N
h.	Crouch:	Y	OR	N
i.	Crawl:	Y	OR	N
j.	Climb ladders, ropes, or scaffolds:	Y	OR	N
k.	Climb ramps or stairs:	Y	OR	N
l.	Use either or both of your hands for fine movements such as typing or buttoning:	Y	OR	N
m.	Reach with either or both hands:	Y	OR	N
n.	Reach above your head:	Y	OR	N
o.	Breathe (i.e. frequent shortness of breath):	Y	OR	N
p.	Sleep:	Y	OR	N
q.	Pay attention/concentrate:	Y	OR	N
r.	Grip or grasp items:	Y	OR	N

28. Do you require a cane or walker to stand or walk?_____

29. Do you lie down to rest during the day?_____

30. Do you experience extreme fatigue?_____

31. Do you elevate either or both of your legs to relieve pain? _____

32. Do you have difficulty with social situations?_____

33. Is it now more difficult for you to deal with stress? _____

34. What is the primary issue that keeps you from returning to work?

_____

_____

_____

_____

_____

_____

35. Please describe your past work history over the 15 years prior to your onset date:

Start Date (approximate)	End Date (approximate)	Employer Name	Job

36. Could you now perform any of this past work? YES NO

37. If yes, which job(s)?

_____

_____

_____

38. If not, why not?

_____

_____

_____

_____

39. Is there anything else you feel Nye & Associates needs to know about your claim?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

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FOR ATTORNEY ONLY

1. Date of Denial Letter: _____

2. Denial Appealed Already? Y OR N By who? _____

   When Appealed: _____

3. Alleged Onset Date: _____ (date impairments prevented work)

4. Last Date Worked? _____ Fired? Laid Off? Restrictions? Quit/Fired impair?

   _____

5. Impairments:

   _____

   _____

   _____

   _____

   _____

6. What doctors may provide RFC? _____

7. PCP? _____

8. Frequency:

   _____

   _____

9. ADL/DIL?

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

10. Diagnostics?

Facility	Type	Order?

11. Medical Records

Facility/Doctor	Order?	Recurring?