SOCIAL SECURITY DISABILITY INTAKE INFORMATION QUESTIONNAIRE BOROJEVIC LAW FIRM, LLC.

Date:

Name: _____ Social Security #:

Mailing Address:

City: _____ State: _____ Zip Code:

Street Address (if different from above):

City: _____ State: _____ Zip Code:

How long have you lived at your current address:

Home: (____) _____ Cell: (____) _____ Friend: (____)

Height: _____ Weight: _____ Date of Birth:

Place of Birth: _____ Highest School Grade Completed:

High School Graduate: □ Yes □ No GED: □ Yes □ No Trade School: □ Yes □ No

Name, Address, Relationship and Telephone Number of Closest Living Relative:

Name: _____ Phone: (____) _____Relationship:

Address:

City: _____ State: _____ Zip Code:

Work History

Date of Employment (approximately)	**Name and address of Employer**	**Duties Performed**
From: To:		
From: To:		
From: To:		
From: To:		
From: To:		

What is the last date you worked at any job?

On what date did you become disabled?

Why did you become disabled on that date?

Is this the first time you have applied for SSDI/SSI: □ Yes □ No

What is the date of your last denial letter:

List prior date/dates applied for SSDI/SSI:

Have you been turned down for disability benefits? If so, for each denial, please state when it happened and if appealed the denial?

Where did you live when you became disabled? _____Is this disability application for your own social security number account? □ yes □ no

If not, then under whose account was the application made?

Name: _____ Social Security #:

Is your application for social security disability insurance (SSDI), based on what you paid into social security when you worked? □ yes □ no or for SSI above? □ yes □ no

Have you continuously paid into your social security account while earning money for work over the last fifteen years? □ yes □ no If no, in what years did you not pay into your social security account?

What is the benefit amount should receive monthly through social security disability? $_____/month

Have you applied for or are you receiving VA disability benefits? □ yes □ no If yes, in the line of duty? □ yes □ no (Please bring you VA Disability Award letter with you to your first interview with Borojevic Law Firm LLC.

What is the benefit amount you were told you would receive monthly through VA disability (if applicable)? $_____/month

Are you receiving long term disability benefits? □ yes □ no If yes, please state the amount: $_____the state where you were awarded benefits: _____ the name of the carrier: _____ the dates of receipt of these benefits:

Are you receiving workers= compensation benefits? □ yes □ no If yes, please state the amount: $_____ the state where you were awarded benefits: _____ the name of the carrier: _____ the dates of receipt of these benefits: _____(If your workers' compensation has settled, please bring in workers' compensation settlement documents)

Are you receiving any federal disability pension? □ yes □ no If yes, please state the amount, $_____the state where you were awarded benefits:

The dates of receipt of these benefits:

MEDICAL INFORMATION

We need medical evidence to prove a disability claim. Please list all treating medical providers, their names and telephone numbers and the dates of care provided. This means all treating physicians, hospitals, psychiatrists, mental health care facilities, and diagnostic facilities. If you have already listed this information elsewhere, please provide us with a separate list and attach it to this page.

What doctor(s) have recommended you apply for disability?

What doctor knows the most about your disabling condition(s)?

How often do you now see him or her?

What medical testing told your doctor and you that you are disabled?

Have you ever been diagnosed with or treated for drug or alcohol abuse? □ yes □ no

If so, when _____ and where

Have you been receiving free medical care from a county or government supported facility? □ yes □ no If yes, where:

These are my treating physicians;

1. Dr. _____ Specialty:

   Phone: (____) _____ Fax: (_____)

   Address: _____
   City: _____ State: _____ Zip Code:

   Approximate dates of treatment:

   Frequency of treatment/visits:

2. Dr. _____ Specialty:

   Phone: (____) _____ Fax: (_____)

   Address: _____
   City: _____ State: _____ Zip Code:

   Approximate dates of treatment:

   Frequency of treatment/visits:

3. Dr. _____ Specialty:

Phone: (____) _____ Fax: (_____)

Address: _____
City: _____ State: _____ Zip Code:

Approximate dates of treatment:

Frequency of treatment/visits:

4. Dr. _____ Specialty:

Phone: (____) _____ Fax: (_____)

Address: _____
City: _____ State: _____ Zip Code:

Approximate dates of treatment:

Frequency of treatment/visits:

These are the hospitals where I have received care:

1. Name: _____ Phone: (_____)

Address: _____
City: _____ State: _____ Zip Code:

Approximate dates of treatment:

Frequency of treatment/visits:

2. Name: _____ Phone: (_____)

Address: _____
City: _____ State: _____ Zip Code:

Approximate dates of treatment:

Frequency of treatment/visits:

These are the facilities where I have been tested:
Please list the contact information for the places where you had diagnostic tests done, like MRI, Xray, nerve conduction study, CT scan, blood tests, etc.

1. Name: _____ Phone: (_____)

Address: _____
City: _____ State: _____ Zip Code:

Approximate dates of test(s) :

2. Name: _____ Phone: (_____)

Address: _____
City: _____ State: _____ Zip Code:

Approximate dates of test(s) :

3. Name: _____ Phone: (_____)

Address: _____
City: _____ State: _____ Zip Code:

Approximate dates of test(s) :

These are the names of the mental health facilities where I received care:

1.. Name: _____ Phone: (_____)

Address: _____
City: _____ State: _____ Zip Code:

Approximate dates of treatment:

Frequency of treatment/visits:

2. Name: _____ Phone: (_____)

Address: _____
City: _____ State: _____ Zip Code:

Approximate dates of treatment:

Frequency of treatment/visits:

Medications
Please list below or attach a list of your medications, the dosage, frequency of use, prescribing physician, and side effects:

1. Medication: _____ Dosage: _____ Dr.
Side Effects: □ no □ yes, describe:

2. Medication: _____ Dosage: _____ Dr.

Side Effects: □ no □ yes; describe:

3. Medication: _____ Dosage: _____ Dr.

Side Effects: □ no □ yes; describe:

4. Medication: _____ Dosage: _____ Dr.

Side Effects: □ no □ yes; describe:

5. Medication: _____ Dosage: _____ Dr.

Side Effects: □ no □ yes; describe:

Miscellaneous

Who can testify as a witness at your disability hearing?

Name: _____ Relationship:

Address:

Telephone: (____)

How long have you know this person?

What is the frequency of contact your currently have with him or her?
Have you ever been incarcerated? □ yes □ no If so, when_____ and where:

Comments or concerns?

Are you currently represented by an attorney in your social security disability matter?
□ yes □ no; (if you are, then you must either obtain in writing your attorney's written consent to speak to us or discharge your attorney before a member of our firm will meet with you to discuss your disability case.

_____Signature of Claimant