COMMUNITY ADVOCATES
Where Meeting Basic Needs Inspires Hope

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DISABILITY ADVOCACY SERVICES CLIENT QUESTIONNAIRE

NAME

OTHER NAMES USED

ADDRESS

CITY | STATE | ZIP

PHONE NUMBER(S)

DATE OF BIRTH | SOCIAL SECURITY NUMBER

ABOUT YOUR SOCIAL SECURITY DISABILITY CLAIM

When did you first apply for Social Security Disability benefits? ____________________

Have you been denied Social Security Disability benefits? ☐ Yes ☐ No

What is the date of your last denial? ____________________

Have you appealed your last denial? ☐ Yes ☐ No

Have you worked with another lawyer or representative who helped you with your disability claim? ☐ Yes ☐ No

If so, give name and address: ____________________

Is your doctor or doctors supportive of your disability claim? ☐ Yes ☐ No

Have you filed for Worker's Compensation or Unemployment? ☐ Yes ☐ No

ABOUT YOUR CONDITION

What are all of the physical or mental conditions affecting you, no matter how serious?

____

____

____

____

When did these conditions first affect you? Please be specific.

____

____

____

____

What medications are you taking? Please be specific. Please add additional pages if you need to list more medications. Include over-the-counter medications.

1.

NAME OF DRUG | DOSAGE/FREQUENCY

WHO PRESCRIBED IT?

WHY DO YOU TAKE IT?

2.

NAME OF DRUG | DOSAGE/FREQUENCY

WHO PRESCRIBED IT?

WHY DO YOU TAKE IT?

3.

NAME OF DRUG | DOSAGE/FREQUENCY

WHO PRESCRIBED IT?

WHY DO YOU TAKE IT?

4.

NAME OF DRUG | DOSAGE/FREQUENCY

WHO PRESCRIBED IT?

WHY DO YOU TAKE IT?

Do you have any side effects from your medications:

What doctors do you see for your condition(s)?

1.

NAME OF DOCTOR

COMPLETE ADDRESS

PHONE NUMBER

WHY DO YOU SEE THIS DOCTOR?

2.

NAME OF DOCTOR

COMPLETE ADDRESS

PHONE NUMBER

WHY DO YOU SEE THIS DOCTOR?

3.

NAME OF DOCTOR

COMPLETE ADDRESS

PHONE NUMBER

WHY DO YOU SEE THIS DOCTOR?

4.

NAME OF DOCTOR

COMPLETE ADDRESS

PHONE NUMBER

WHY DO YOU SEE THIS DOCTOR?

ABOUT YOUR EDUCATION AND WORK HISTORY

What was the last year of school you completed? ______

Do you have any specialized vocational training, certificates, licenses, etc? ______

______

When did you last work? ______

Why did you stop working? ______

Please list all the jobs you have held during the past 15 years chronologically, starting with the most recent job first.

1.

EMPLOYER | YOUR TITLE

WHAT DID YOU DO AT THIS JOB?

WHEN DID YOU WORK THERE? | WHY DID YOU LEAVE?

2.

EMPLOYER | YOUR TITLE

WHAT DID YOU DO AT THIS JOB?

WHEN DID YOU WORK THERE? | WHY DID YOU LEAVE?

3.

EMPLOYER | YOUR TITLE

WHAT DID YOU DO AT THIS JOB?

WHEN DID YOU WORK THERE? | WHY DID YOU LEAVE?

4.

EMPLOYER | YOUR TITLE

WHAT DID YOU DO AT THIS JOB?

WHEN DID YOU WORK THERE? | WHY DID YOU LEAVE?

Please add additional pages if necessary.

ABOUT YOUR DAILY LIFE

How does your condition or conditions affect your ability to perform personal, household and daily living tasks (such as cleaning, bathing, shopping, cooking, walking, etc.)? Please be specific and give examples. If you need help doing certain things, explain.

Do you take care of any children: ☐ Yes ☐ No

If so, how does your condition or conditions affect your ability to care for them?

How do you spend a typical day?

Do you ever use alcohol? ☐ Yes ☐ No

If so, what do you drink, and how much/how often? ______________________________

Do you ever use street drugs? ☐ Yes ☐ No

If so, what, how much, and how often? ______________________________

Have you ever received treatment for drug or alcohol dependence? ☐ Yes ☐ No

If so, please give dates and locations:

DATE	LOCATION

Have you ever been in jail or prison? ☐ Yes ☐ No

If so, please give details: ______________________________

Additional information: ______________________________

Did you need help completing this form? ☐ Yes ☐ No

If so, give the name and phone number of the person who helped you:

NAME	PHONE NUMBER

____
YOUR SIGNATURE

____
TODAY'S DATE