SOCIAL SECURITY APPLICATION QUESTIONNAIRE FORM

Name: SSN:

Street Address: DOB: Age:

City: State: Zip Code:

Phone: Alt Phone: Email:

Name of Emergency contact: Phone:

City and State of Birth: Mothers Maiden Name:

Other Known Names (Maiden Names or Other Married Names):

Height: Weight:

What is the last date you worked?
Is this the first time you have applied for SSDI/SSI: ❑ Yes ❑ No
What is the date of your last denial letter?

Marital Status:

Have you ever been married? ❑ Yes ❑ No
Currently Married? ❑ Yes ❑ No
If **YES**
Date Marriage Began:_____City and State Marriage Began: _____
Spouses Name: _____ Date of Birth: _____
If **NO** but Divorced or Widowed and Marriage lasted 10 or more years:
Spouses Name:_____ Date of Birth: _____ SSN (if known): _____
Date Marriage Began:_____City and State Marriage Began: _____
Date Marriage Ended:_____City and State Marriage Ended: _____
Have any Children? ❑ Yes ❑ No
Have Dependent Children under the age of 19: ❑ Yes ❑ No
Names of Dependent Children: _____

Education:

High School Graduate: ❑ Yes ❑ No Highest School Level of Education Completed: _____
What Year: _____
GED: ❑ Yes ❑ No Trade School: ❑ Yes ❑ No

Past Employment:

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

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

If worked in 2020, how much have you earned total to date? $_____

If worked in 2019, how much did you earn total for that year? $_____

Do you receive state Medicaid and benefits like food stamps or cash assistance?

❑ Yes ❑ No If yes, what?: _____

Treating Physicians

1. Dr. _____ Specialty:
   Phone: (____) _____ Fax:
   Address: _____
   City: _____ State: _____ Zip Code: _____
   Approximate dates of treatment for disability: _____
   Treating for and Frequency of treatment/visits:

2. Dr. _____ Specialty:
   Phone: (____) _____ Fax:
   Address: _____
   City: _____ State: _____ Zip Code:
   Approximate dates of treatment for disability:
   Treating for and Frequency of treatment/visits:

3. Dr. _____ Specialty:
   Phone: (____) _____ Fax:
   Address: _____
   City: _____ State: _____ Zip Code: _____
   Approximate dates of treatment for disability: _____
   Treatment for and Frequency of treatment/visits:

4. Dr. _____ Specialty:
   Phone: Fax:
   Address: _____
   City: _____ State: _____ Zip Code: _____
   Approximate dates of treatment for disability: _____
   Treatment for and Frequency of treatment/visits:

5. Dr. _____ Specialty:
   Phone: (____) _____ Fax:
   Address: _____
   City: _____ State: _____ Zip Code: _____
   Approximate dates of treatment for disability: _____
   Treatment for and 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 for disability:
   Treatment for and Frequency of treatment/visits:

2. Name: _____ Phone: (_____)
   Address: _____
   City: _____ State: _____ Zip Code: _____
   Approximate dates of treatment for disability:
   Treatment for and 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:
Treatment for and Frequency of treatment/visits:

2. Name: _____ Phone: (_____)
Address: _____
City: _____ State: _____ Zip Code: _____
Approximate dates of treatment:
Treatment for and 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: