CARLSON, MEISSNER HART & HAYSLETT, P.A.

The Law Offices of Carlson & Meissner

CLIENT INTAKE SHEET
SOCIAL SECURITY

Date : _____

Referred by: _____

TV ___(Brighthouse) ___(Verizon Fios)

Social Security Number: _____ - _____ - _____

Name : _____

Address : _____ Date of Birth: _____ Age : _____

_____ Height : _____ Weight : _____

Telephone: Home_____ Work_____ Cell _____

Email Address: _____

I am granting permission for the law firm to forward confidential information to me regarding my case via Email. Yes/No

Marital status : _____ Spouses name & SSN: _____

Children under age 18 - provide names, dates of birth & Soc. Sec. No.:

_____

Please provide the name and telephone number of closest relative or friend who can be contacted if we are unable to reach you?

_____

Have you applied for:
Disability Yes / No
SSI Yes / NO
Both Yes / NO

What stage are you at?
_____Initial filing
_____Reconsideration
_____Hearing
_____Appeals Council

What Social Security *Office* did you file your application at?

_____

List your health problems:_____

_____

Date last worked: _____

Where were you employed? _____

What did you do?_____

Why did you stop working? _____

Last grade completed in school: _____

Have you ever been treated for drug or alcohol abuse? _____

For each doctor, chiropractor, psychologist, psychological counselor, etc. you have seen, please complete the following chart.

List the doctors you are seeing now first and work your way back to about five years before you became unable to work.

NAME AND ADDRESS OF DOCTOR	DATE OF FIRST VISIT	DATE OF LAST VISIT	HOW MANY VISITS TOTAL	WHICH CONDITION WAS TREATED	DESCRIBE ANY RESTRICTION OF ACTIVITIES IMPOSED OR WHAT YOU WERE TOLD ABOUT YOUR CONDITION

HOSPITALIZATIONS

For each hospitalization, please complete the following chart
List your most recent hospitalization first and work your way back to about five years before you became unable to work.

NAME AND ADDRESS OF HOSPITAL	APPROXIMATE DATES	WHY WERE YOU HOSPITALIZED	DESCRIBE THE TREATMENT YOU RECEIVED	NAMES OF DOCTORS WHO TREATED YOU

MEDICATIONS

For each prescription drug you are presently taking, please complete the following chart.

NAME OF MEDICATION AND DOSAGE	DAILY AMOUNT TAKEN	FOR WHICH CONDITION	NAME OF PRESCRIBING DOCTOR	APPROXIMATE DATE STARTED	IDENTIFY SIDE EFFECTS YOU ARE HAVING FROM THIS DRUG

NONPRESCRIPTION MEDICATIONS:

WORK HISTORY

Please provide your work history for 15 years before you became unable to work.
Start with your most recent job and then the next most recent job, etc.

DATES OF EMPLOYMENT	NAME AND ADDRESS OF EMPLOYER	JOB DUTIES	HOURS PER DAY	REASON FOR LEAVING	HOURS PER WEEK	RATE OF PAY
			Sitting: _____ Standing: _____ Walking: _____			
			Sitting: _____ Standing: _____ Walking: _____			
			Sitting: _____ Standing: _____ Walking: _____			
			Sitting: _____ Standing: _____ Walking: _____			
			Sitting: _____ Standing: _____ Walking: _____			
			Sitting: _____ Standing: _____ Walking: _____			