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THE RATLIFF LAW FIRM
A Professional Corporation

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Social Security Disability/SSI Intake Questionnaire

Please fill in the information requested below. If you have difficulty understanding or reading the material, you may have a friend or family member help you or bring the document to your first meeting.

1. Name:

2. Address:

3. Date of Birth and Social Security Number:

4. Marital Status:

5. Dependant Children? If yes, please list names, ages and Social Security Numbers:

6. Can you read and write?

7. Can you understand articles in a newspaper and/or write and punctuate a letter?

8. How much education do you have? Please be specific and include degrees, diplomas and on-the-job training.

9. What is the source of your income? Include all details such as spousal income, insurance, food stamps, pension, etc.

10. What date are you claiming as the onset date of your disability?

11. What physical ailment you to be disabled? List all impairments, including aches and pains and depression.

12. How do your impairments affect you?

13. How do your impairments prevent you from working?

14. Do you perform outside tasks?

15. Are you active socially (such as Church, lodge, veterans affairs, family)?

16. Were you in the military service? Please list dates.

17. Describe a typical day in your life. Be specific with times and activities.

18. Do you need to rest often? How often and how?

19. Are you easily fatigued? Explain.

20. Do you have headaches? Explain how often, severity and length.

21. Do you get dizzy? How often, how severe, how long?

22. Do you get blurred vision? How often, how severe, how long?

23. Do you have difficulty driving. Please explain.

24. How much do you drive in an average week?

25. How far can you walk?

26. How long can you
    a) Sit?
    b) Stand?

27. How much weight can you lift?

28. Can you bathe and dress yourself? Explain if no.

29. Are you under a doctor's care (include pain management, therapists and counselors). List all with address and phone number.

30. List all doctors, hospitals and clinics you have been a patient at in the last ten years.

31. Are you receiving any therapy (physical and/or mental)?

32. What medicines are you taking? Please list which doctor prescribed the medication, the dosage and the amount you take daily.

33. Do you have any side effects from the medication? Please list each medication and the respective side effects.

34. Please list your height and weight.

35. Have you lost or gained weight in the last six months? If so, how much and why.

36. Do you have problems with your hands? Explain.

37. Which hand do you use to write and manipulate?

38. Do you have vision problems?

39. Why did you stop working and when?

40. Where you terminated because you were physically unable to do your job or were you laid off or did you quit?

41. Why can't you go back to your last job?

42. Are you working now? Where? When did you start?

43. Have you attempted to perform any other type of work, including part-time or volunteer? Please explain.

44. Have you considered other types of work or additional training for new types of work?

Please answer the following questions for each previous job held during the past 15 years.

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: ______			

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: _______			

Form Approved
OMB No. 0960-0623

WHOSE *Records to be Disclosed*

NAME *(First, Middle, Last, Suffix)*	
SSN	Birthday *(mm/dd/yy)*

AUTHORIZATION TO DISCLOSE INFORMATION TO THE SOCIAL SECURITY ADMINISTRATION (SSA)

**** PLEASE READ THE ENTIRE FORM, BOTH PAGES, BEFORE SIGNING BELOW ****

I voluntarily authorize and request disclosure (including paper, oral, and electronic interchange):
OF WHAT ***All my medical records;* also education records and other information related to my ability to perform tasks. This includes specific permission to release:**

1. **All records and other information regarding my treatment, hospitalization, and outpatient care for my impairment(s) *Including*, and not limited to :**
   - Psychological, psychiatric or other mental impairment(s) (excludes "psychotherapy notes" as defined in 45 CFR 164.501)
   - Drug abuse, alcoholism, or other substance abuse
   - Sickle cell anemia
   - Records which may indicate the presence of a communicable or noncommunicable disease; and tests for or records of HIV/AIDS
   - Gene-related impairments (including genetic test results)
2. **Information about how my impairment(s) affects my ability to complete tasks and activities of daily living, and affects my ability to work.**
3. **Copies of educational tests or evaluations, including Individualized Educational Programs, triennial assessments, psychological and speech evaluations, and any other records that can help evaluate function; also teachers' observations and evaluations.**
4. **Information created within 12 months after the date this authorization is signed, as well as past information.**

FROM WHOM

- **All medical sources** (hospitals, clinics, labs, physicians, psychologists, etc.) including mental health, correctional, addiction treatment, and VA health care facilities
- All educational sources (schools, teachers, records administrators, counselors, etc.)
- Social workers/rehabilitation counselors
- Consulting examiners used by SSA
- Employers, insurance companies, workers' compensation programs
- Others who may know about my condition (family, neighbors, friends, public officials)

THIS BOX TO BE COMPLETED BY SSA/DDS (as needed) Additional information to identify the subject (e.g., other names used), the specific source, or the material to be disclosed:

TO WHOM **The Social Security Administration and to the State agency authorized to process my case** (usually called "disability determination services"), **including contract copy services, and doctors or other professionals consulted during the process.** [Also, for international claims, to the U.S. Department of State Foreign Service Post.]

PURPOSE Determining my **eligibility for benefits**, including looking at the combined effect of any impairments that by themselves would not meet SSA's definition of disability; and whether I can manage such benefits.

☐ Determining whether I am **capable of managing benefits ONLY** (check only if this applies)

EXPIRES WHEN This authorization is good for 12 months from the date signed (below my signature).

- I authorize the use of a copy (including electronic copy) of this form for the disclosure of the information described above.
- I understand that there are some circumstances in which this information may be redisclosed to other parties (see page 2 for details).
- I may write to SSA and my sources to revoke this authorization at any time (see page 2 for details).
- SSA will give me a copy of this form if I ask; I may ask the source to allow me to inspect or get a copy of material to be disclosed.
- **I have read both pages of this form and agree to the disclosures above from the types of sources listed.**

PLEASE SIGN USING BLUE OR BLACK INK ONLY **INDIVIDUAL authorizing disclosure** **SIGN ▶**	**IF not signed by subject of disclosure, specify basis for authority to sign** ☐ **Parent of minor** ☐ **Guardian** ☐ **Other personal representative (explain)** (Parent/guardian/personal representative sign here if two signatures required by State law) ▶

Date Signed	Street Address		
Phone Number (with area code)	City	State	ZIP

WITNESS *I know the person signing this form or am satisfied of this person's identity:*

SIGN ▶	IF needed, second witness sign here (e.g., if signed with "X" above) **SIGN ▶**
Phone Number (or Address)	Phone Number (or Address)

This general and special authorization to disclose was developed to comply with the provisions regarding disclosure of medical, educational, and other information under P.L. 104-191 ("HIPAA"); 45 CFR parts 160 and 164; 42 U.S. Code section 290dd-2; 42 CFR part 2; 38 U.S. Code section 7332; 38 CFR 1.475; 20 U.S. Code section 1232g ("FERPA"); 34 CFR parts 99 and 300; and State law.

Social Security Administration
Please read the Instructions before completing this form.

Form Approved
OMB No. 0960-0527

Name (Claimant) (Print or Type)	Social Security Number – –
Wage Earner (If Different)	Social Security Number – –

Part I

APPOINTMENT OF REPRESENTATIVE

I appoint this person, ______________________________
(Name and Address)

to act as my representative in connection with my claim(s) or asserted right(s) under:

☐ Title II (RSDI) ☐ Title XVI (SSI) ☐ Title XVIII (Medicare Coverage) ☐ Title VIII (SVB)

This person may, entirely in my place, make any request or give any notice; give or draw out evidence or information; get information; and receive any notice in connection with my pending claim(s) or asserted right(s).

☐ I authorize the Social Security Administration to release information about my pending claim(s) or asserted right(s) to designated associates who perform administrative duties (e.g. clerks), partners, and/or parties under contractual arrangements (e.g. copying services) for or with my representative.

☐ I appoint, or I now have, more than one representative. My main representative is ______________________________
(Name of Principal Representative)

Signature (Claimant)	Address	
Telephone Number (with Area Code) ( ) –	Fax Number (with Area Code) ( ) –	Date

Part II

ACCEPTANCE OF APPOINTMENT

I, ______________________________, hereby accept the above appointment. I certify that I have not been suspended or prohibited from practice before the Social Security Administration; that I am not disqualified from representing the claimant as a current or former officer or employee of the United States; and that I will not charge or collect any fee for the representation, even if a third party will pay the fee, unless it has been approved in accordance with the laws and rules referred to on the reverse side of the representative's copy of this form. If I decide not to charge or collect a fee for the representation, I will notify the Social Security Administration. (Completion of Part III satisfies this requirement.)

Check one: ☐ I am an attorney. ☐ I am a non-attorney eligible for direct payment under SSA law.
☐ I am a non-attorney not eligible for direct payment.

I am now or have previously been disbarred or suspended from a court or bar to which I was previously admitted to practice as an attorney. ☐ YES ☐ NO

I am now or have previously been disqualified from participating in or appearing before a Federal program or agency. ☐ YES ☐ NO

I declare under penalty of perjury that I have examined all the information on this form, and on any accompanying statements or forms, and it is true and correct to the best of my knowledge.

Signature (Representative)	Address	
Telephone Number (with Area Code) ( ) –	Fax Number (with Area Code) ( ) –	Date

Part III

FEE ARRANGEMENT

(Select an option, sign and date this section.)

☐ **Charging a fee and requesting direct payment** of the fee from withheld past-due benefits. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Charging a fee but waiving direct payment** of the fee from withheld past-due benefits --I do not qualify for or do not request direct payment. *(SSA must authorize the fee unless a regulatory exception applies.)*

☐ **Waiving fees and expenses from the claimant and any auxiliary beneficiaries** --By checking this block I certify that my fee will be paid by a third-party, and that the claimant and any auxiliary beneficiaries are free of all liability, directly or indirectly, in whole or in part, to pay any fee or expenses to me or anyone as a result of their claim(s) or asserted right(s). *(SSA does not need to authorize the fee if a third-party entity or a government agency will pay from its funds the fee and any expenses for this appointment. Do not check this block if a third-party individual will pay the fee.)*

☐ **Waiving fees from any source** --I am waiving my right to charge and collect any fee, under sections 206 and 1631(d)(2) of the Social Security Act. I release my client and any auxiliary beneficiaries from any obligations, contractual or otherwise, which may be owed to me for services provided in connection with their claim(s) or asserted right(s).

Signature (Representative)	Date

Form Approved
OMB No. 0960-0681

FUNCTION REPORT - ADULT

How your illnesses, injuries, or conditions limit your activities

For SSA Use Only
Do not write in this box.

Related SSN ____________

Number Holder ____________

SECTION A - GENERAL INFORMATION

1. **NAME OF DISABLED PERSON** *(First, Middle Initial, Last)*	2. **SOCIAL SECURITY NUMBER**

3. **YOUR DAYTIME TELEPHONE NUMBER** *(If there is no telephone number where you can be reached, please give us a daytime number where we can leave a message for you.)*

________ ____________ ☐ Your Number ☐ Message Number ☐ None

Area Code *Phone Number*

4. a. Where do you live? *(Check one.)*

☐ House ☐ Apartment ☐ Boarding House ☐ Nursing Home
☐ Shelter ☐ Group Home ☐ Other *(What?)* ____________

b. With whom do you live? *(Check one.)*

☐ Alone ☐ With Family ☐ With Friends
☐ Other *(Describe relationship.)* ____________

SECTION B - INFORMATION ABOUT YOUR ILLNESSES, INJURIES, OR CONDITIONS

5. How do your illnesses, injuries, or conditions limit your ability to work?

SECTION C - INFORMATION ABOUT DAILY ACTIVITIES

6. Describe what you do from the time you wake up until going to bed.

7. Do you take care of anyone else such as a wife/husband, children, grandchildren, parents, friend, other? ☐ Yes ☐ No

   If "YES," for whom do you care, and what do you do for them?

8. Do you take care of pets or other animals? ☐ Yes ☐ No

   If "YES," what do you do for them?

9. Does anyone help you care for other people or animals? ☐ Yes ☐ No

   If "YES," who helps, and what do they do to help?

10. What were you able to do before your illnesses, injuries, or conditions that you can't do now?

11. Do the illnesses, injuries, or conditions affect your sleep? ☐ Yes ☐ No

    If "YES," how?

12. **PERSONAL CARE** (Check here ☐ if **NO PROBLEM** with personal care.)

    a. Explain how your illnesses, injuries, or conditions affect your ability to:

    Dress

    Bathe

    Care for hair

    Shave

    Feed self

    Use the toilet

    Other

b. Do you need any special reminders to take care of personal needs and grooming? ☐ Yes ☐ No

If "YES," what type of help or reminders are needed? ______________________

____

c. Do you need help or reminders taking medicine? ☐ Yes ☐ No

If "YES," what kind of help do you need? ______________________

____

13. **MEALS**

a. Do you prepare your own meals? ☐ Yes ☐ No

If "Yes," what kind of food do you prepare? (For example, sandwiches, frozen dinners, or complete meals with several courses.) ______________________

____

How often do you prepare food or meals? (For example, daily, weekly, monthly.)

____

How long does it take you? ______________________

Any changes in cooking habits since the illness, injuries, or conditions began?

____

b. If "No," explain why you cannot or do not prepare meals. ______________________

____

14. **HOUSE AND YARD WORK**

a. List household chores, both indoors and outdoors, that you are able to do. (For example, cleaning, laundry, household repairs, ironing, mowing, etc.) ______________________

____

b. How much time does it take you, and how often do you do each of these things?

____

c. Do you need help or encouragement doing these things? ☐ Yes ☐ No

If "YES," what help is needed? ______________________

____

d. If you don't do house or yard work, explain why not. ______________________

____

15. **GETTING AROUND**

a. How often do you go outside? ______________________

If you don't go out at all, explain why not. ______________________

____

b. When going out, how do you travel? *(Check all that apply.)*

☐ Walk ☐ Drive a car ☐ Ride in a car ☐ Ride a bicycle

☐ Use public transportation ☐ Other *(Explain)* ______________________

c. When going out, can you go out alone? ☐ Yes ☐ No

If "NO," explain why you can't go out alone. ______________________

____

d. Do you drive? ☐ Yes ☐ No

If you don't drive, explain why not. ______________________

____

16. **SHOPPING**

a. If you do any shopping, do you shop: *(Check all that apply.)*

☐ In stores ☐ By phone ☐ By mail ☐ By computer

b. Describe what you shop for. ______________________

____

c. How often do you shop and how long does it take? ______________________

____

17. **MONEY**

a. Are you able to:

Pay bills	☐ Yes	☐ No	Handle a savings account	☐ Yes	☐ No
Count change	☐ Yes	☐ No	Use a checkbook/money orders	☐ Yes	☐ No

Explain all "NO" answers. ______________________

____

b. Has your ability to handle money changed since the illnesses, injuries, or conditions began? ☐ Yes ☐ No

If "YES," explain how the ability to handle money has changed. ______________________

____

18. HOBBIES AND INTERESTS

a. What are your hobbies and interests? (For example, reading, watching TV, sewing, playing sports, etc.)

____

____

b. How often and how well do you do these things? ______________________

____

c. Describe any changes in these activities since the illnesses, injuries, or conditions began.

____

____

19. SOCIAL ACTIVITIES

a. Do you spend time with others? *(In person, on the phone, on the computer, etc.)* ☐ Yes ☐ No

If "YES," describe the kinds of things you do with others. ______________________

____

How often do you do these things? ______________________

b. List the places you go on a regular basis. (For example, church, community center, sports events, social groups, etc.) ______________________

____

Do you need to be reminded to go places? ☐ Yes ☐ No

How often do you go and how much do you take part? ______________________

____

Do you need someone to accompany you? ☐ Yes ☐ No

c. Do you have any problems getting along with family, friends, neighbors, or others? ☐ Yes ☐ No

If "YES," explain. ______________________________

____

d. Describe any changes in social activities since the illnesses, injuries, or conditions began.

____

____

SECTION D - INFORMATION ABOUT ABILITIES

20. a. Check any of the following items that your illnesses, injuries, or conditions affect:

☐ Lifting	☐ Walking	☐ Stair Climbing	☐ Understanding
☐ Squatting	☐ Sitting	☐ Seeing	☐ Following Instructions
☐ Bending	☐ Kneeling	☐ Memory	☐ Using Hands
☐ Standing	☐ Talking	☐ Completing Tasks	☐ Getting Along With Others
☐ Reaching	☐ Hearing	☐ Concentration	

Please explain how your illnesses, injuries, or conditions affect each of the items you checked. (For example, you can only lift [how many pounds], or you can only walk [how far])

____

____

____

b. Are you: ☐ Right Handed? ☐ Left Handed?

c. How far can you walk before needing to stop and rest? ______________________________

If you have to rest, how long before you can resume walking? ______________________________

____

d. For how long can you pay attention? ______________________________

e. Do you finish what you start? *(For example, a conversation, chores, reading, watching a movie.)* ☐ Yes ☐ No

f. How well do you follow written instructions? (For example, a recipe.) ______________________________

____

g. How well do you follow spoken instructions? ______________________________

____

____

h. How well do you get along with authority figures? (For example, police, bosses, landlords or teachers.) ______________________________

____

i. Have you ever been fired or laid off from a job because of problems getting along with other people? ☐ Yes ☐ No

If "YES," please explain. ______________________________

____

If "YES," please give name of employer. ______________________________

j. How well do you handle stress? ______________________________

____

k. How well do you handle changes in routine? ______________________________

____

l. Have you noticed any unusual behavior or fears? ☐ Yes ☐ No

If "YES," please explain. ______________________________

____

21. Do you use any of the following? *(Check all that apply.)*

☐ Crutches ☐ Cane ☐ Hearing Aid
☐ Walker ☐ Brace/Splint ☐ Glasses/Contact Lenses
☐ Wheelchair ☐ Artificial Limb ☐ Artificial Voice Box
☐ Other (Explain) ______________________________

Which of these were prescribed by a doctor? ______________________________

____

When was it prescribed? ______________________________

____

When do you need to use these aids? ______________________________

____

22. Do you currently take any medicines for your illnesses, injuries, or conditions? ☐ Yes ☐ No

If "YES, "do any of your medicines cause side effects? ☐ Yes ☐ No

If "YES," please explain. (Do not list all of the medicines that you take. List only the medicines that cause side effects.)

NAME OF MEDICINE	SIDE EFFECTS YOU HAVE

SECTION E - REMARKS

Use this section for any added information you did not show in earlier parts of this form. When you are done with this section (or if you didn't have anything to add), be sure to complete the fields at the bottom of this page.

Name of person completing this form (Please print)		Date *(month, day, year)*
Address (Number and Street)	Email address (optional)	
City	State	ZIP Code