Please try to complete the attached questionnaire.

**Please know that the information you provide could prove invaluable to the effective handling of your case. If you have difficulty completing the questionnaire for any reason, please do not worry as we can assist you at the time of your consultation.

Thank you.

Pamela I. Atkins, Attorney-at-Law
Atkins & Associates, Attorneys-at-Law, L.L.C.

Phone: (770) 399-9999
Fax: (770) 399-9939

Today's Date: _______________

SOCIAL SECURITY NEW CLIENT INFORMATION
ATKINS & ASSOCIATES, ATTORNEYS-AT-LAW, LLC

PERSONAL INFORMATION

Your full name:____ SS#:______________ Sex: M / F_

a/k/a (other names used): ____

Address: Street:____

City:______________________________ State:_______________ Zip:_____________________

Mailing Address (if different):____

City:______________________________ State:_______________ Zip:_____________________

Email addresses:_1.________________@______________________2.________________@_____________

Primary Phone:______________________________ Cell Phone:___________________________________

Emergency contact: name#1:_______________________________Phone: ______________Relation:________

name#2:___________________________________Phone: _______________Relation:____________________

DOB:_____________ Age:_______ US Citizen: Y[] N[] Do you have a driver's license? Y[] N[]

Have you ever served in the military? []Yes []No If so, please complete the following:

Dates of service: ___________ to ______________ Branch:________________________ Rank: _______

Type of discharge:__________________________ Duties performed: __________________________

Have you ever been arrested? Y [] N[] When and what for?_____________________________________

Have you ever been incarcerated? Y[] N[] When and what for?_________________________________

Are you currently on probation? Y[] N[] Are you currently on parole Y[] N[]

Marital Status: []Married _____yrs. [] Single []Divorced []Widowed, date of death _________ []Separated

Spouse:____________________________________ SS#:______________________ DOB:___________

Spouse's job:______________________________________ employer:_______________________________

Is spouse blind or disabled? []Yes []No Is spouse getting Social Security benefits?: []Yes []No

Names and dates of birth of any children/step-children:

1.____ 4.__________________________________
2.____ 5.__________________________________
3.____ 6.__________________________________

Housing: []house []Apt. []Trailer []Condo []Rooming house []Group Home []Homeless []Own []Rent

Names of persons who live with you/Relationship:

1.____ 4.__________________________________
2.____ 5.__________________________________
3.____ 6.__________________________________

INCOME-Household

[] Spouse's employment $_________________ every *[]week []two-weeks []twice-a-month []month []year*

[] Social Security or SSI $ _________________ *every month for [] spouse or [] self*

[] STD, SLDT or LTD Benefits $_________________ every *month* *Carrier:*___________________________

[] Workers' Compensation

Weekly benefit: $___________ Benefits commenced on: ______________________________________

WC Carrier:_________________________ WC Atty:____

Amount of settlement or expected date of settlement:____

[] VA Benefits: $_________________ every *[]week []month*

[] AFDC Benefits: $_________________ every *month*

[] Food Stamps: $_________________ every *month*

[] Unemployment Benefits:$______________ every *week*; benefits started:_______________ended:___________

[] General Assistance: $_________________ every *month*

[] Other Benefits/Income from:_________________$_____________ every *[]week []two-weeks []month []year*

*[] Assets-things you own worth more than $2,000 :*____

CLAIM INFORMATION

1. On what date did you apply for social security disability and/or SSI benefits? ___________________
2. In your application, what date did you state as the date you became unable to work? _____________
3. Have you ever filed any other applications for benefits or contacted any government agency for advice or assistance in filing for Social Security disability or SSI? If Yes, when?____________
4. When were you last denied Social Security benefits? ____

EDUCATION

Please provide your educational history:

	NAME OF SCHOOL, COUNTY, STATE	DATES ATTENDED	AGE	SPECIAL EDUCATION OR CIRCUMSTANCES
ELEMENTRY SCHOOL				
MIDDLE SCHOOL				
HIGH SCHOOL				
GED				
TRADE SCHOOL				
COLLEGE				

1. What was the highest grade you completed in school? ________________ How old were you?
   Why did you leave school?____
   Did you fail or repeat any grades in school or attend any special education classes? Yes [] No []
   Explain:____
2. Can you: Read: Well [] Not Well [] No [] Write: Well [] Not Well [] No []
   Can you perform simple math (add, subtract, multiple & divide)?: Well [] Not Well [] No []
   Can you count money and make the correct change? Yes [] No []
   Please describe any problems you have reading, writing or performing simple math:____________
   ____
   ____
3. If you cannot read or write well, please comment on the following:
   Who is completing this form? []self []other name/relationship:_______________________________
   Who usually does your reading/writing for you?____
   Did you take a written driver's test? Yes [] No []
   Can you read simple instructions and lists? Yes [] No []
   Can you find a telephone number? Yes [] No []

4. Have you had any special vocational training? Yes [] No []
For any vocational training you have had in your life, please complete the following:

SCHOOL OR ORGANIZATION/Address/phone	TYPE OF COURSE	DATES

Do you have any special degrees or licenses? Yes [] No [] If Yes, List:________________________
____

WORK HISTORY

1. Are you currently working? Yes[] No[] If so, describe what you do and how often.__________________
2. Have you worked at all since the onset of your disability? Yes [] No []
3. Have you looked for work? Yes [] No []
4. Is there any work you think you could do? Yes [] No [] If yes, please describe the work you think you could do. ____
5. Before you left your last job, did your medical problems require you to make any changes in the hours of work, the way you worked, your job duties, absences, etc? If so, what were these changes?

____

Please list your work for the last 15 years. List your most recent job first and then your next most recent job,etc... (prior to becoming disabled)

1. Last Employer:____ Dates:______________ to___
Employer's Address:____
Job Title:______________________________ Reason for Leaving: ___________________________
Brief description:____
____
____

2. Employer:____ Dates:______________ to_______
Employer's Address:____
Job Title:______________________________ Reason for Leaving: ___________________________
Brief description:____
____
____

3. Employer:____ Dates:______________ to_______
Employer's Address:____
Job Title:______________________________ Reason for Leaving: ___________________________
Brief description:____
____
____

4. Employer:____ Dates:______________ to_______
Employer's Address:____
Job Title:______________________________ Reason for Leaving: ___________________________
Brief description:____
____
____

5. Employer:____ Dates:______________ to_______
Employer's Address:____
Job Title:______________________________ Reason for Leaving: ___________________________
Brief description:____
____

____

6. Employer:______________________________________ Dates:__________ to______
Employer's Address:____
Job Title:____________________ Reason for Leaving: ______________________
Brief description:____
____
____

7. Employer:______________________________________ Dates:__________ to______
Employer's Address:____
Job Title:____________________ Reason for Leaving: ______________________
Brief description:____
____
____

8. Employer:______________________________________ Dates:__________ to______
Employer's Address:____
Job Title:____________________ Reason for Leaving: ______________________
Brief description:____
____
____

9. Employer:______________________________________ Dates:__________ to______
Employer's Address:____
Job Title:____________________ Reason for Leaving: ______________________
Brief description:____
____
____

10. Employer:______________________________________ Dates:__________ to______
Employer's Address:____
Job Title:____________________ Reason for Leaving: ______________________
Brief description:____

MEDICAL CONDITION

Please list any health problems which interfere with your ability to work (list them in order of severity):

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____

Do you have any *current* problem with any of the following?

Shortness of breath	Yes	No	Alcohol addiction	Yes	No
Coughing up blood	Yes	No	High blood pressure	Yes	No
Hot/cold flashes	Yes	No	Dizziness	Yes	No
Excessive sweating	Yes	No	Swelling of feet/ankles	Yes	No
Heart palpitations	Yes	No	Blackouts	Yes	No
Diarrhea	Yes	No	Fatigue	Yes	No

Controlling your urine	Yes	No	Difficulty sleeping	Yes	No
Vision or Hearing Loss	Yes	No	Recent weight loss	Yes	No
Drug addiction	Yes	No	Recent weight gain	Yes	No

Which condition do you consider to be your primary disability or impairment?:____________________________

When did this condition first begin:____________________

Just prior to your disability date were you free of symptoms? Yes[] No[]

Since the onset date has your condition been getting better or worse? better [ ] worse [ ]

evidenced by:____

Will you ever be well enough to work again? Y [] N [] When?____________________________________

Height: ___________ Weight: ____________ Is this your normal weight?Yes[] No[] Explain:__________

Handedness: Right [] Left [] Do you have any problems using your hands or arms? Yes[] No[]

Have you received medical attention for all the health problems you listed? [ ] Yes [ ] No

Conditions not diagnosed or treated: ____

Have you suffered from any mental health impairment, including depression and anxiety? [ ] Yes [ ] No

Please describe this condition and how long you have suffered from it: ______________________________

Are you able to sustain attention and concentration for 2 hours at a time? [ ] Yes [ ]No

If no, how long can you sustain attention and concentration?____

Are your interests restricted due to your health problems? [ ] Yes [ ] No

If yes, please give examples:____

MEDICAL TREATMENT: **Are your presently under doctor's care: []Yes []No

DOCTORS

Please list all the doctors that have treated you.

1. Doctor:____ Specialty:__________________________
   Office:____ Phone:__________________________
   Address:____
   City:___________________________________ State:______________ Zip:______________________
   First Seen:___________________ Last Seen:_________________ Next Appt.:______________________

2. Doctor:____ Specialty:__________________________
   Office:____ Phone:__________________________
   Address:____
   City:___________________________________ State:______________ Zip:______________________
   First Seen:___________________ Last Seen:_________________ Next Appt.:______________________

3. Doctor:____ Specialty:__________________________
   Office:____ Phone:__________________________
   Address:____
   City:___________________________________ State:______________ Zip:______________________
   First Seen:___________________ Last Seen:_________________ Next Appt.:______________________

4. Doctor:____ Specialty:__________________________
   Office:____ Phone:__________________________
   Address:____
   City:___________________________________ State:______________ Zip:______________________
   First Seen:___________________ Last Seen:_________________ Next Appt.:______________________

5. Doctor:________________________ Specialty:________________
Office:________________________ Phone:________________
Address:____
City:________________ State:________ Zip:____________
First Seen:__________ Last Seen:__________ Next Appt.:____________

6. Doctor:________________________ Specialty:________________
Office:________________________ Phone:________________
Address:____
City:________________ State:________ Zip:____________
First Seen:__________ Last Seen:__________ Next Appt.:____________

7. Doctor:________________________ Specialty:________________
Office:________________________ Phone:________________
Address:____
City:________________ State:________ Zip:____________
First Seen:__________ Last Seen:__________ Next Appt.:____________

8. Doctor:________________________ Specialty:________________
Office:________________________ Phone:________________
Address:____
City:________________ State:________ Zip:____________
First Seen:__________ Last Seen:__________ Next Appt.:____________

9. Doctor:________________________ Specialty:________________
Office:________________________ Phone:________________
Address:____
City:________________ State:________ Zip:____________
First Seen:__________ Last Seen:__________ Next Appt.:____________

10.Doctor:________________________ Specialty:________________
Office:________________________ Phone:________________
Address:____
City:________________ State:________ Zip:____________
First Seen:__________ Last Seen:__________ Next Appt.:____________

HOSPITALS

Please list all the hospitals that have treated you for all conditions related to your current disability.

Grady Card Number?:____________________ VA claim Number?:____________

1. Hospital:________________________ Doctor:________________
Address:____
Dates:__________ to __________ [] In-Patient [] Out-Patient [] Emergency Room
Purpose:____
____
____

2. Hospital:________________________ Doctor:________________
Address:____
Dates:__________ to __________ [] I/P [] O/P [] E/R
Purpose:____
____
____

3. Hospital:____ Doctor:____________________
Address:____
Dates:____________ to ____________ [] I/P [] O/P [] E/R
Purpose:____
____
____

4. Hospital:____ Doctor:____________________
Address:____
Dates:____________ to ____________ [] I/P [] O/P [] E/R
Purpose:____
____
____

5. Hospital:____ Doctor:____________________
Address:____
Dates:____________ to ____________ [] I/P [] O/P [] E/R
Purpose:____
____
____

DAILY MEDICATIONS

Pharmacy Name:____________________ Address:______________________________________
____Phone No:____________________

Please list all of the medications you are presently taking.

Drug Dosage Frequency Condition Prescribing Doctor

1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____
11.____
12.____

OVER-THE-COUNTER MEDICATIONS

Drug Dosage Frequency Condition

1.____
2.____
3.____

YOUR DAILY ACTIVITIES:

Miles per week:____ Where do you drive?:____
Longest trip as passenger/driver since onset of disability:____
Problems driving:____

	SEVERAL TIMES A DAY	DAILY	WEEKLY	MONTHLY	NEVER	Explain: (i.e. need help; do a poor job; in bed next day)
Drive						
Cook						
Wash dishes						
Straighten up house						
Dust						
Vacuum						
Mop floor						
Do laundry						
Clean bathroom						
Make bed						
Change bed sheets						
Yard work						
Gardening						
Visit family/friends						
Fix things						
Grocery shopping						
Pay bills, handle finances						
Watch children						

Watch TV or Listen to radio	**number of hours per day:**	
Read	**number of hours per day:**	

Talk on phone	number of hours per day:	
Sleep /stay in bed	number of hours per day:	
Sleep/ lie on couch	number of hours per day:	

ONGOING ASSISTANCE: **Does anyone have to help you to do things around the house on a regular basis? Who? What do they do?**

____

____

____

____

	SEVERAL TIMES A DAY	DAILY	WEEKLY	MONTHLY	NEVER	Explain (difficulties, poor performance, etc..)
Groom self						
Participate in organizations						
Go to church						
Play cards /games						
Attend sports events						
Hobbies (*name*)						
Visit relatives						
Visit friends						
Talk to neighbors						
Go out to eat or to movies						
Use public Transportation						
Exercise						
Other activities (*name*)						

PHYSICAL & MENTAL LIMITATIONS:

NOTE: If your disability is psychiatric and you have no physicallimitations, it is not necessary to complete questions in this section, please skip to the section labeled psychiatric questionnaire.

1. *SITTING*:

Do you have any trouble sitting?	Yes	No
Does it make a difference what kind of chair you sit on?	Yes	No
What kind of chair is best for you?		
Do you elevate your legs while sitting?	Yes	No
Where do you have pain or discomfort when you sit too long?		
What do you do to relieve that pain or discomfort?		

List examples of activities you have trouble performing while sitting:

____

____

____

a. What is your best estimate of how long you can sit *continuously in one stretch* in a work chair (*not* a recliner) before you must get up and move around or lie down?

Hours/minutes:_____

b. If you were sitting on and off throughout a workday, how many hours *total* out of an 8-hour workday in a regular work setting can you sit?

Hours:____________

2. *STANDING:*

Do you have any trouble standing?	Yes	No
Where do you have pain or discomfort when you stand too long?		
What do you do to relieve that pain or discomfort?		

List examples of activities you have trouble performing while standing:

____

____

____

a. What is your best estimate of how long you can stand *continuously in one stretch* without sitting down or walking around?

Hours/minutes:_____

b. If you were standing on and off throughout a workday, how many hours *total* out of out of an 8-hour workday in a regular work setting can you stand?

Hours: ____________

3. *WALKING:*

Do you have any trouble walking?	Yes	No
Do you ever use a cane or other device to help you walk?	**Yes**	**No**
Where do you have pain or discomfort when you walk too long?		
What do you do to relieve that pain or discomfort?		

List examples of activities you have trouble performing while walking:

____

____

____

a. What is your best estimate of how far you can walk *continuously in one stretch* without stopping to rest?

Blocks:_________________

b. How many hours *total* out of an 8-hour workday in a regular work setting can you walk?

Hours:____

4. *LIFTING AND CARRYING:*

Do you have any problems lifting or carrying?	Yes	No
What is the heaviest thing that you encounter in your everyday life which you can still lift or carry (for example, gallon of milk, 8-pack of soda, a bag of groceries, basket of laundry, small children or grandchildren)?		
What happens when you try to lift or carry too much?		

List examples of things you encounter in your daily life that you can no longer lift or carry:

____

____

a. What is your best estimate of the maximum weight you can lift or carry in a regular work situation if you only had to do it *once in a while?*

_______________________________ __________________

b. What is your best estimate of the maximum weight you can lift or carry in a regular work situation if you had to do it *frequently* (that is, from one-third to two-thirds of the workday)?

____

5. *ARMS AND HANDS:*

Are you left or right handed?	Left	Right
Do you have any problems using your hands or arms?	Yes	No
Do the problems occur with repetitive use of your hands or arms?	Yes	No
Can you make a fist with each hand?	Yes	No
Can you touch each finger to the thumb on each hand?	Yes	No
Do your hands shake?	Yes	No
Do you have any trouble with your hands being numb or having pins and needles?	Yes	No
Do you have any trouble with dropping things?	Yes	No
Have you lost strength in your hands or arms?	Yes	No
Can you reach above your head (for example, to put things away in kitchen cupboards)?	Yes	No

List examples of activities you have difficulty performing with your hands:

___

___

6. *LEGS AND FEET:*

Do you have any trouble using your legs or feet?	Yes	No
Do you have any trouble using your legs and feet to drive a car?	Yes	No

Describe the difficulty.

___

___

7. *OTHER EXERTIONAL LIMITATIONS:*

Do you have trouble doing any of the following things?	Yes	No

If yes, complete the following:

		CAN'T DO AT ALL	ONCE IS OKAY	A FEW TIMES PER HOUR IS OKAY	REPETITIVELY IS OKAY
A.	Bending:				
B.	Twisting:				
C.	Squatting:				
D.	Climbing stairs:				

8. *ENVIRONMENTAL RESTRICTIONS:* **Are there any restrictions on your activities, or problems which you encounter, having to do with any of the following situations? Describe the problem:**

a. Unprotected heights:

____

b. Being around moving machinery:

____

c. Exposure to marked changes in temperature or humidity:

____

d. Exposure to dust, fumes or gases:

____

9. Mental Limitations: Do you have any *current* problem with any of the following?

Depression	Yes	No	Dealing with the public	Yes	No
Anxiety attacks	Yes	No	Relating to other people	Yes	No
Memory	Yes	No	Maintaining attention	Yes	No
Dealing with stress	Yes	No	Loss of concentration	Yes	No

10. *GOOD DAYS AND BAD DAYS:*

a. Do you have good days and bad days? Yes No

b. Approximately how many days per month are good days? ________

Approximately how many days per month are bad days? ________

c. What tends to produce good days?

____

____

d. What is a good day like?

____

____

e. What tends to produce bad days?

____

____

f. What is a bad day like?

____

____

PAIN:

11. If your disability involves pain, answer the following: (If pain is not your problem, go on to question #16.)

a. Approximate date pain began: ______________________________________

b. What event caused the pain (e.g. accident, disease, surgery, unknown):

____

c. What does your pain feel like:

____

d. What reasons have your doctors given for your pain?

____

e. Are any of the following associated with your pain? Check those that apply:

	Numbness		**Tingling (pins and needles)**		**Weakness**
	Increased sweating		**Muscle spasm**		**Skin discoloration**
	Nausea		**Loss of sleep**		**Crying spells**
	Loss of concentration		**Depression**		**Agitation**

f. Location of pain: Please details the areas of pain.

____

g. Is pain: Constant Often Occasional

h. How many hours per day do you have pain? ________

i. If you do not have pain every day, estimate how many hours of pain per week, or days per week or month.
____

j. Below is a list of activities. For each activity indicate how it affects your pain.

		INCREASES	DECREASES	NO EFFECT
(1)	Lying down			
(2)	Sitting			
(3)	Rising from Sitting			
(4)	Standing			

(5)	Walking			
(6)	Bending			
(7)	Coughing/ Sneezing			

k. What other activities or things increase your pain?

____

l. Below is a list of treatments you may have used to relieve pain. For each of these, check whether you have tried and whether they helped.

		NEVER TRIED	TRIED	HELPED	DIDN'T HELP
(1)	Heat				
(2)	Massage				
(3)	Whirlpool				
(4)	Traction				
(5)	Prescribed Exercise				
(6)	TNS (or TCS or TENS, transcutaneous stimulation)				
(7)	Biofeedback				
(8)	Trigger Point Injections				
(9)	Nerve Blocks				
(10)	Acupuncture				
(11)	Chiropractic Treatments				
(12)	Behavior Modification				
(13)	Counseling				
(14)	Back School				
(15)	Pain Clinic				

m. What other things relieve your pain?

____

n. **How much and how often do you drink alcoholic beverages?**

o. **Does drinking alcoholic beverages relieve your pain?**

p. **Rate your pain by circling the *one* number that best describes it.**

(A rating of 10 would indicate pain so severe as to prohibit all activity -the worst pain you have ever had.)

NONE VERY SEVERE					**MODERATE**				
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

q. **How much does the pain interfere with your activities? Circle the *one* number that describes the amount of interference.**

(A rating of 10 would indicate pain so severe as to prohibit all activity -the worst pain you have ever had.)

NONE VERY SEVERE					**MODERATE**				
1	**2**	**3**	**4**	**5**	**6**	**7**	**8**	**9**	**10**

r. **If you did not have pain, what things would you do that you cannot do now because of the pain?**

ADDITIONAL COMMENTS / EXTRA SPACE:

I Hereby certify that this questionnaire has been completed to the best of my ability, and that all responses on this questionnaire are true to the best of my knowledge.

Signature **Date**