

## SOCIAL SECURITY INFORMATION SHEET

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Work Phone Number: \_\_\_\_\_

Phone Number of relative or neighbor where you can be reached: \_\_\_\_\_

Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

Height: \_\_\_\_\_ Present Weight: \_\_\_\_\_ Normal Weight: \_\_\_\_\_

Address: \_\_\_\_\_  
\_\_\_\_\_

Place of birth: \_\_\_\_\_

Marital status: \_\_\_\_\_ Date of marriage: \_\_\_\_\_

Number of previous marriages: \_\_\_\_\_

Do you have any children living with a previous husband or wife:  
\_\_\_\_\_

How many people are in your home: \_\_\_\_\_

Names and birthdays of children under age 22: \_\_\_\_\_  
\_\_\_\_\_

Other children's first names: \_\_\_\_\_  
\_\_\_\_\_

Have you filed a Social Security claim in the past: \_\_\_\_\_

If Yes, When: \_\_\_\_\_

Did you have a lawyer: \_\_\_\_\_ If Yes, Who: \_\_\_\_\_

Do you have a claim pending or on appeal at this time: \_\_\_\_\_

### **INCOME OR COMPENSATION**

Military Compensation: VA Benefits: \_\_\_\_\_

Service connected: \_\_\_\_\_ Non-Service connected: \_\_\_\_\_

Have you ever received workmen's compensation: \_\_\_\_\_ If so, give details (Employer, Insurance Company, Claim Number, Type of injury, payments received, lump sum settlement, etc.) \_\_\_\_\_  
\_\_\_\_\_

If you had an attorney, who was it: \_\_\_\_\_

Does anyone else in your household work: \_\_\_\_\_ Who: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you or anyone in your household receive any other income from any other source: \_\_\_\_\_ If Yes, explain who gets it, how much and source (welfare, company or union benefits, wages, etc.):

\_\_\_\_\_

Are you renting or buying your home: \_\_\_\_\_

**EDUCATION OR MILITARY SERVICE**

Highest grade completed: \_\_\_\_\_

Specialized training of any kind: \_\_\_\_\_

\_\_\_\_\_

Has your employment ever involved the use of tools, machines, equipment, technical knowledge or special skills, or supervisory responsibility (explain): \_\_\_\_\_

\_\_\_\_\_

If you did not finish high school, did you get a G.E.D.: \_\_\_\_\_ If Yes, when: \_\_\_\_\_

Did you ever receive vocational rehabilitation: \_\_\_\_\_ If Yes, When: \_\_\_\_\_

Military service (dates, branch, etc.) \_\_\_\_\_

Any special training while in the service: \_\_\_\_\_

\_\_\_\_\_

**EMPLOYMENT HISTORY**

Kind of work done most of working life: \_\_\_\_\_

\_\_\_\_\_

Have you ever worked on railroads since January 1, 1937: \_\_\_\_\_

Have you ever been self-employed: \_\_\_\_\_ If Yes, give details: \_\_\_\_\_

\_\_\_\_\_

State your earnings for the last tax year: \_\_\_\_\_ State your earnings so far this tax year: \_\_\_\_\_

**Work History** (Begin with most recent job and go backward to when you left school)

<u>Name</u>	<u>Kind of Work</u>	<u>Began</u>	<u>Ended</u>

**MEDICAL HISTORY**

What medical problems keep you from working (What is your disability): \_\_\_\_\_

What medication are you presently taking and who prescribed it:

Hospitalizations and emergency room visits: (Begin with the most recent and go backward. Give name and address of hospital, reason for admission, dates of hospitalization and if you were admitted as an out-patient or in-patient.) \_\_\_\_\_

List of doctors and who have treated or examined you (including doctors Social Security has sent you to):

Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ How often seen: \_\_\_\_\_ First seen: \_\_\_\_\_ Last seen: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ How often seen: \_\_\_\_\_ First seen: \_\_\_\_\_ Last seen: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

Doctor: \_\_\_\_\_

Address: \_\_\_\_\_

Phone: \_\_\_\_\_ How often seen: \_\_\_\_\_ First seen: \_\_\_\_\_ Last seen: \_\_\_\_\_

Reason for visit: \_\_\_\_\_

When did the worst condition which prevents you from working first start: \_\_\_\_\_

When did the condition first cause you to stop working: \_\_\_\_\_

Did you go back to work any time: \_\_\_\_\_ If Yes, give details: \_\_\_\_\_

Since your condition first bothered you, have you:

Changed job duties: \_\_\_\_\_ Changed hours of work: \_\_\_\_\_ Missed work: \_\_\_\_\_

**PRESENT ACTIVITIES AND CAPABILITIES**

At the present time, do you:

Drive a car: \_\_\_\_\_ How often: \_\_\_\_\_

How far can you walk without trouble: \_\_\_\_\_

How long can you stand in one place: \_\_\_\_\_

Sit in one place: \_\_\_\_\_

Do you have any trouble bending or stooping: \_\_\_\_\_

Any trouble with your arms or legs: \_\_\_\_\_

Can you pick up and carry a ten pound weight: \_\_\_\_\_

Do you visit relatives or friends: \_\_\_\_\_

Go to church or club meetings: \_\_\_\_\_

Do you have trouble bathing or dressing yourself: \_\_\_\_\_

Do you read: \_\_\_\_\_ Watch television: \_\_\_\_\_ Fish or hunt: \_\_\_\_\_ Other sports: \_\_\_\_\_

Work around the house: \_\_\_\_\_ Do you exercise: \_\_\_\_\_ Can you go shopping: \_\_\_\_\_

Any lawn or garden work: \_\_\_\_\_ Did you do any of these things before you became disabled (Describe) \_\_\_\_\_

A typical day (you get up in the morning, what do you do all day): \_\_\_\_\_

Appetite: (Check one)  Good  Fair  Poor

Sleep: (Check one)  Good  Fair  Poor

Do you suffer pain: \_\_\_\_\_ If Yes, what parts of your body and how bad is it: \_\_\_\_\_

What other problems do you have: \_\_\_\_\_

What has a doctor told you: \_\_\_\_\_

Not to try to work at all [ ] OR try to go back to work [ ]

When and which doctor: \_\_\_\_\_

What did the doctor say: \_\_\_\_\_

Use this additional space if you need to complete any questions:

**Please mail to:**

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