Lowenthal & Abrams, PC

SSDI Initial Intake Form©

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These are the questions we ask our clients during our initial consultation for SSDI claims. You may find it helpful to complete this form ahead of time. While it is not required, if you prefer, you may FAX completed forms to Jared’s attention at 610-667-3440. Please do not email this form. Email is not entirely secure. **You are not required to complete the entire form. Our attorney will ask you these questions during the initial interview.**

Consultations with Lowenthal & Abrams’ SSDI lawyer are free. When you retain us, there is no fee unless we are successful on your behalf.

Please understand, completing this form does not create an attorney/client relationship between you and any of the attorneys of Lowenthal & Abrams. An attorney/client relationship is only formed upon signing of a fee agreement with this firm.

Name:

Age:

Phone:

Email:

Work History and Benefits

1. When was your last day of work?
    a. Was your job full time?
    b. If not, how many hours per week?

2. Provide your work history for the 15 years prior to your current disability.

a. What was the heaviest weight you lifted during those jobs?

   i. How heavy were the things you lifted most of the day?

   ii. What other heavy work besides lifting did you perform for your job?

3. Have you previously applied for Social Security? If yes, at what stage were you? (Initial claim, appeal, etc.)

4. Are you currently receiving worker's compensation or unemployment compensation?
   a. If so, how much and how often?

Education

5. What is your highest level of education?
   a. Have you completed any vocational or trade schools?
      i. What?

Family

6. Do you have any dependents? (These include a spouse, children under 18 living at home, children 18/19 still living at home and still in high school, parents who receive financial support)

Disability

7. What parts of your body are impacted by your disabilities?

8. What injuries (if any) do you have?

9. How do you feel during the day?

    a. How do you feel at night?

        i. Do you feel worse at night due to your activities during the day?

10. What daily activities can you perform? (Check those you can perform.)

    a. Driving

    b. Cooking

        i. If yes, what do you cook? (i.e. full meals, microwaveable things, sandwiches.)

        ii. How often do you cook?

    c. Household chores? (Laundry, vacuuming, dusting, etc.)

    d. Shopping

    e. Hobbies

    f. Do you need help for any of these activities?

        i. If yes, who helps you?

Medical Care

11. Who is your current family doctor?

    a. Have you had any other family doctors during the past 5 years? If so, please list them.

    b. Have you seen any specialists? If so, identify type and name.

    c. Have you been to the emergency room due to your disabilities? If so, when, where and why?

    d. Have you had any surgeries? What? Were they related to your disabilities?

    e. Have you had any other hospitalizations? When, where and why?

    f. Are you taking any medications? List with dosage.

    g. Which doctor prescribed each medication?

    h. Why are you taking each medication? State whether the medication is related to your disabilities. (Yes or No.)

    i. How long have you taken each medication?

    j. Please provide the names and addresses for all of the pharmacies/drug stores that you have used in the last 5 years.

12. Has any doctor told you at any time that you cannot work?

13. Has any doctor told you that you cannot do specific things?

Limitations

14. Do you have limitations? Please explain each one and state which doctor(s) know about those limitations or provided those limitations.

    a. Walking

    b. Standing

    c. Sitting

    d. Pushing

    e. Squatting

    f. Lifting

Your Thoughts

15. Why do you believe that you are disabled?