

AMICK, STEVENS & GADNESS

ATTORNEYS AT LAW

2222 West Spring Creek Pkwy., Suite 101
Plano, Texas 75023

CONFIDENTIAL INTERVIEW INFORMATION - SOCIAL SECURITY

(Please print clearly - Thank you.)

Full Name: _____ Maiden Name: _____

Address: _____

City: _____ County: _____ State: _____ Zip: _____

Home #: (____) _____ Work #: (____) _____

Mobile: (____) _____ Email: _____

Fax #: (____) _____ Best # to be reached at: _____

Social Security Number: _____ Date of Birth: _____

Driver's License #: _____

Employer: _____

Employer's Address: _____

Spouse's Name: _____ Work #: (____) _____

Name, Address, and Telephone Number of Someone Who Can Always Contact You: _____

How Did You Hear about Us:

- Internet / Firm Web site Phone Book (City: _____)
- Greensheet Plano Profile Magazine
- Other: _____
- Referred by _____ (May we send a thank you letter? Yes No)

NOTICE TO CLIENTS

There is no charge for this consultation. The purpose of the consultation is to determine if the client wants to retain an attorney. The attorney cannot give specific legal advice on the case unless retained by written contract.

The State Bar investigates and prosecutes professional misconduct committed by Texas attorneys. Although not every complaint against or dispute with a lawyer involves professional misconduct, the State Bar's office of general counsel will provide you with information about how to file a complaint if you feel one is warranted. You may call 1-800-932-1900 for more information.

ALL ATTORNEYS ARE REQUIRED BY LAW TO REPORT ANY FORM OF CHILD OR ELDER ABUSE. ANY CONVERSATIONS WITH THE ATTORNEYS REGARDING CHILD OR ELDER ABUSE ARE NOT PRIVILEGED. THE ATTORNEYS IN THIS OFFICE MUST REPORT CHILD ABUSE OR ELDER ABUSE TO THE PROPER AUTHORITIES.

I have read and understand the above.

Client Signature

Date

Please bring the following information to your interview:

1. The attached form, fully completed.
2. All papers from the Social Security Administration (including but not limited to all denials, application, all forms you completed, statement of earnings, and anything else you received regarding your disability claim).
3. A list of your current doctors and all hospitals, rehabilitation centers, etc. that have treated you, beginning at least one year before your disability began. We need the name of the provider, address, phone number, and approximate dates you were treated by the provider. If you have a business card or statement from your doctor, bring it - however, you do not need to write out the address and phone number if you bring something with that information that we can copy.
4. A list of your current prescription medications. This list should include the name of the medication, dose (e.g 3 300 mg tablets, to be taken 3 times a day), and physician who prescribed the medication.
5. Any medical records you have in your possession. (You do not have to go to your doctor to get your records, just bring any that you happen to have.)

SOCIAL SECURITY DISABILITY - CLIENT INFORMATION PERSONAL HISTORY

Name: _____

Age: _____ Birth date: _____ Social Security Number: _____

Height: _____ Present Weight: _____ Normal Weight: _____

Marital Status: _____

Where is your local Social Security Office?:

McKinney
North Dallas
Other _____

Greenville
Sherman

Who is your representative at your local office? _____

Do you have children or stepchildren who are under the age of 18? If so, state their names, ages, and Social Security Numbers: _____

Do you have children or stepchildren of any age who are handicapped? If so, state their names and ages: _____

Have you filed a Social Security claim in the past? (other than the one which is now pending) Yes [] No []

If your answer to the previous question is "Yes" please state the approximate date of the applications and the name of the lawyer, if any, who represented you. _____

When did you file your current Social Security claim?: _____

What date did you give Social Security as the date on which you were no longer able to work? _____

What will your monthly benefit be (if you know)? _____

What will your minor child(ren)'s monthly benefit be (if you know)? _____

What was your "Date Last Insured" (if you know) _____

INCOME OR COMPENSATION

Do you receive VA or other military benefits? Yes [] No []

If your answer to the previous question is "Yes", please state the type of benefits and amount per month.

Have you ever received workman's compensation? Yes [] No []

If your answer to the previous question is "Yes", give details (Employer, Insurance company, type of injury, payments received, lump sum settlement, lawyer representing you, etc.) _____

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, do you have a G.E.D.? _____

Military service (dates and branch): _____

Any special training while in the service? _____

EMPLOYMENT HISTORY

State the date on which you last worked. _____

State your earnings so far this year: _____

State your earnings for the last tax year: _____

What year is the most recent year in which you worked the entire year? _____

State your earnings for that year: _____

WORK HISTORY

(Begin with your most recent job and go back for 15 years.)

Name of Employer	Type of Work	Years in Job

MEDICAL HISTORY

What medical problems keep you from working (What is your disability)? _____

When did the worst condition which prevents you from working first start? _____

When did your medical problems become so severe that you stopped working? _____

HOSPITALIZATIONS

For every time you were hospitalized, beginning one year before your onset date and continuing to the date on which you fill out this form, whether as an in-patient or out-patient, give the requested information: (Begin with your most recent hospitalization and go backward.)

Hospital	Date Admitted	Date Discharged	Medical Problem

MAIN TREATING DOCTOR

Name of your Main Treating Doctor: _____

Specialty, if any, of your main treating doctor: _____

When did you first see this doctor? _____

How often do you see this doctor? _____

When did you last see this doctor? _____

Has this doctor ever told you that you needed surgery for your condition? Yes [] No []

Did you have the recommended surgery? Yes [] No []

Has this doctor ever told you not to work? Yes [] No []

OTHER DOCTORS

For all other doctors you have seen, beginning one year before your onset date and continuing to the date on which you fill out this form, please state the following:

Name of Physician	Date of First Visit	Date of Last Visit	Number of Visits	Your Condition Which Was Treated
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SOCIAL SECURITY DOCTOR (If the Social Security Administration sent you to a doctor for a Consultative Examination.)

1. Name and Address of Doctor _____

2. After he/she examined you, what did he/she say? _____

DRUGS/ALCOHOL

1. Do you have a drinking problem? Yes [] No []

If yes, explain: _____

2. Have any of your family, friends or a physician called you an alcoholic?
Yes [] No []

If yes, explain: _____

3. Do you use drugs, prescription or not? Yes [] No []

If yes, what drugs: _____

I have read the foregoing and affirm that it is true and correct to the best of my knowledge and belief.

Your Signature

Date