

# AMICK & STEVENS

----- 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 #: \_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_

General Nature of Consultation: \_\_\_\_\_

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

How Did You Hear about Us:

Internet / Firm Web site

Phone Book

Plano Profile Magazine

Referred by \_\_\_\_\_

**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.

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

Steppington, Dallas

Other \_\_\_\_\_

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 and ages: \_\_\_\_\_

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. \_\_\_\_\_

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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? \_\_\_\_\_

**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.

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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.) \_\_\_\_\_

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**EDUCATION OR MILITARY SERVICE**

Highest grade completed: \_\_\_\_\_ Specialized training of any kind:

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

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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.)

| <u>Name of Employer</u> | <u>Type of Work</u> | <u>Number of Years in Job</u> |
|-------------------------|---------------------|-------------------------------|
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**MEDICAL HISTORY**

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

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

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

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**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 \_\_\_\_\_

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**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 of Doctor \_\_\_\_\_
2. Address of Doctor \_\_\_\_\_
3. What type of specialty did this doctor practice (if you know)?  
\_\_\_\_\_

4. 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.

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Your Signature

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Date