J. NICKOLAS ALEXANDER, JR., P.A.
Attorney at Law
Florida Bar Certified Family Law Mediator

2037 Carnes Street
Post Office Box 1387
Orange Park, Florida 32073

Telephone: 904-264-0311
Facsimile: 904-264-0673
Email: nickolas@jnalaw.com

SOCIAL SECURITY & SSI DISABILITY QUESTIONNAIRE

Please answer all questions to the best of your ability and return this questionnaire to the office within ten (10) days. Please answer as honestly and completely as you can. If you need more space, use the back of the page or additional paper.

I. PERSONAL

Name:____

Address: ____

____

Telephone (home):_________________Telephone (cell):_________________________

Email address: ____

Social Security No.: ____________________________ Date of Birth: ________________

Place of Birth:____Age: _______

Height: __________ Present Weight: _____________ Normal Weight:______________

Marital Status: Single: _______Married:_______ Divorced:_______ Widowed: _______

If married, present spouse's full name:____

Spouse's Social Security No.: _________________Spouse's Date of Birth: ___________

Spouse's occupation? ____

Spouse's Employer:______________________ Spouse's Wages per month:__________

Former spouse's full name: ____

Social Security No.: ____________________________Date of Birth: ________________

Have you ever been married to someone who is now deceased? ____________________

Deceased spouse's full name: ____

Social Security No.: ____________________________Date of Death: _______________

What is your household's primary source of income? _____________________________

____________________________ Estimated Income per month: ___________________

Current residence: House ______ Mobile Home ______ Apartment _______ Other:_____

Do you have to climb stairs in your home? __________ If so, how many? _____________

Please list the names of all the people who live with you and their relationship to you:

Name	Relationship	Age

Please list the names, dates of birth, and current ages of your children:

Name	Date of Birth	Age

Do you have any childcare responsibilities? If so, please describe:___________________

____

Please note if you receive or have received the following:

Type	Dates Rec'd	Amount	Type	Dates Rec'd	Amount
Welfare			Short Term Disability		
AFDC			Alimony		
Veteran's Benefits			Child Support		
Retirement/Pension			Wage Loss Benefits		
Workers' Comp			Unemployment		
Long Term Disability			Food Stamps		

II. EDUCATION

What is the highest grade you completed in school? _____________ When? __________

Name and location of last school attended: ______________________________________

Why did you leave school?____

Have you had any additional training? ________ What type?_________________________

___________________________ Where?____________________________When?________

Do you have any special skills?_________ If so, specify:_____________________________

____

Do you have any difficulty with the following tasks? If yes, please describe:

Reading: ____

Writing:____

Addition/Subtraction:____

Making change:____

III. MILITARY

Are you a veteran?____________ What branch? ________________________________

Service Dates?_______________Your military job?______________________________

Highest rank achieved?______________ Rank at Discharge?______________________

Do you have a service connected disability?________ If so, your rating? ____________

IV: WORK EXPERIENCE

Please list all jobs you have held for the last 15 years, the names and addresses of your employers, the approximate dates of employment, a brief description of your job duties, and the reason you left each job:

Job Title	Employer	Dates	Job Duties	Reason for Leaving

For each physical requirement, please list the MAXIMUM you performed per day and on which job:

Time spent sitting: __________________ Which job? ______________________________

Time spent standing: ________________ Which job? ______________________________

Time spent walking:_________________ Which job? ______________________________

Weight lifted:______ Weight carried:________ Which job? __________________________

Weight pushed:_________ Weight pulled:_________ Which job? ____________________

Have you supervised anyone? _____ If yes, what jobs did you supervise? __________

Did you have authority to hire/fire employees? _____ If yes, on which job? ___________

List machinery you operated: ____

List hand tools you used:____

What is the date you last worked in any capacity? _________ Where? _______________

Why did you leave this job? ________________ Could you still perform this job?_______

If not, why?____

Have you had any special job training? ______If yes, what type? __________________

____

When is the last time you looked for a job?_________ Job title?____________________

What was the result?____

Do you think you can work in any job right now?______If yes, what kind?_____________

Have you applied for services from the FL Division of Vocational Rehabilitation?_______

If yes, what was the outcome?____

When did you apply? ___________Counselors Name?____________________________

IV: MEDICAL ISSUES

What is the date your disability began? ____________ What are the physical and mental problems that have caused your disability (be specific)? ___________________________

____

____

____

____

Please list your medical problems, date the problems began, and how you are affected:

Medical problem	Date	Affect

Please list the names and addresses of your treating doctors, dates of treatment, and the type of treatment received:

Physician name & address	Treatment Dates	Reason for treatment

Please list the names of prescribed medications you are now taking, how much and how often you take it, for what medical problem and by which doctor is it prescribed, and any side effects:

Name of Medication & Dosage	Reason	Doctor	Side Effects

Please describe the difference in your ability to do the following activities before and after onset of your disability (Ex: Lift - before onset 35 pounds; after onset 5 pounds):

Activity	Before Onset	After Onset
Sit (Example)	I could sit for four hours at a time.	Now I have to get up after one hour.
Sit		
Stand		
Walk		
Run		
Lift		
Carry		
Stoop		
Kneel		
Reach		
Grasp		
Climb		
Breathe		
Tolerate cold		
Tolerate heat		
Hear		
See		
Talk		
Balance		
Memory		
Concentrate		
Handle stress		
Sleep		

What pain do you experience on a regular basis, where is the pain located, how often and how long does the pain last, does the pain vary with the weather or activity, and what do you do to stop the pain?

Location of Pain	Frequency & Duration	What causes increase or decrease in this pain?	Treatment

Do you smoke cigarettes?_______If yes, how much do you smoke?_______________

Do you drink alcohol?_____If yes, how much do you drink?______________________

Has your appetite changed?______ If yes, how has it changed? _______________

V: DAILY ACTIVITIES

Please describe how you spend a typical day including the time you get up and the time you go to bed:____

____

____

____

____

____

____

Please check all activities that you are able to do on a daily or weekly basis:

Activity	Do Daily	Do Weekly	Unable to do	Activity	Do Daily	Do Weekly	Unable to do
Dress yourself				Cook			
Bathe yourself				Dust			
Read				Sweep			
Watch TV				Vacuum			
Listen to music				Laundry			
Make beds				Take out trash			
Wash dishes				Grocery shop			
Visit with friends				Drive			
Visit with relatives				Garden			
Attend church				Go to movies			

Did you need help completing this form? ( ) Yes ( ) No

If yes, who helped you?____

If no, how long did it take you to complete this form? ________________________

_________________________________ Signature

_________________________________ Date