

SOCIAL SECURITY INTERVIEW FORM

Do not e-mail this form

Morriss, Lober & Dobson, LLC

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Macon, Ga. 31201

(478) 745-7700

Name: _____ Mr. Ms. Date: _____

Address: _____ SSN: _____

DOB: _____

Telephone: _____ Age: _____

Message #: _____ Weight: _____

Height: _____

Married Single Widow Divorced Separated

Other names used during relevant time period: _____

Total number of children:	Number of children under 18 or older but still in high school, at anytime after onset date:	Number of stepchildren under 18* who reside with claimant:
Spouse:	Name:	Years Married:

Type of Claim: Social Security Disability _____
Supplemental Security Income _____
Widower's Claim _____
Don't Know _____

Stage of Claim: _____

Prior Applications: Yes No Dates and Results: _____

Name of Attorney that handled claim: _____

Please list all sources of income: _____

Education: Grade Completed _____

Special job training or schooling: _____

Military Service: Yes _____ No _____

If yes, which branch, rank and job? _____

EMPLOYMENT

Date you last worked: _____ Date you became disabled: _____

Please list your employers for the past ten (10) years:

<i>EMPLOYER</i>	<i>JOB TITLE</i>	<i>DATES OF EMPLOYMENT</i>	<i>DUTIES</i>

Did an on-the-job injury contribute to your disability? Yes _____ No _____

If yes, are you now receiving Workers' Compensation? Yes _____ No _____

How much? _____

MEDICAL

Please list all physicians who treated you for the pain/symptoms listed above:

NAME/ADDRESS

DATES TREATED

1. _____

2. _____

3. _____

4. _____

Please list all physicians that are currently treating you and date of your last visit:

Please list the date of your next visit:

Please list all hospitalizations:

HOSPITAL	PURPOSE	DATES
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Have you ever been treated at a mental health center? Yes _____ No _____

If yes, please explain when and why: _____

PRESENT SYMPTOMS

	SYMPTOM 1	SYMPTOM 2	SYMPTOM 3	SYMPTOM 4
Location:				
Description: (consider describing occasional radiation of pain as a separate symptom)				
Frequency:				
Duration:				
What starts it?				
What aggravates it?				
Intensity at its worst 1 - 10:				
Usual intensity 1 - 10:				
Intensity at its best 1 - 10:				
What makes it better?				
Effectiveness of medication:				
Side effects of medication:				

Please list all medications you are currently taking: _____

How *often* do you have any of the following?

Nausea:		Crying spells:	
Fainting:		Headaches:	
Dizziness:		Spasms:	
Bladder control problems:		Cramps:	
Seizures:		Diarrhea:	
Dates of most recent seizures:			

At what pharmacies have you purchased medication from in the past year? _____

Have you had any of the following tests recently?

TEST	WHERE DONE	APPROX. DATE
Treadmill Stress Test		
Other Heart Tests Identify:		
EMG/Electro diagnostic Studies		
X-ray/CAT Scan Part of Body:		
MRI Part of Body:		
Myelogram:		
Breathing Tests:		
MMPI		
Other:		

FAMILY, HOUSING AND INCOME:

List all children who were under 18 (or under 19 and still in high school or disabled adult children) at any time after the alleged onset date. Identify custodian.

CHILDREN'S NAMES	RELATIONSHIP	DOB	CUSTODIAN

How many people are in your household? _____

DAILY ACTIVITIES:

What floor is bedroom on? _____ Trouble with stairs? Yes No

Which is worse, going up stairs or down? Up Down,

Rise: _____ a.m. Retire: _____ p.m.

Do you nap during the day? Yes No Where do you nap? _____

How many times? _____ How long? _____

Do you have rest periods during the day? Yes No

Where do you rest? _____

How many times? _____ How long? _____

Do you have a particular chair, couch, etc. that is most comfortable? Describe: _____

Summary of typical day: _____

Do you attend religious services? Yes No How often? _____

Are you active in any groups, clubs, etc.? Yes No Describe: _____

Are you involved in any volunteer work? Yes No Describe: _____

Present hobbies: _____

Former hobbies that you can no longer do: _____

Do you do any housework? Yes _____ No _____

If yes, what in particular: _____

Does it take you longer than normal to perform these tasks? Yes _____ No _____

Do you do any shopping? Yes _____ No _____

PHYSICAL ASSESSMENT

Assuming that everyone, even the most disabled people, can do some sort of work, describe what you think you can do: _____

If pain is involved, how *often* is your experience of pain severe enough to interfere with attention and concentration?

__ Never __ Seldom __ Often __ Frequently __ Constantly

ENVIRONMENTAL RESTRICTIONS:	NO RESTRICTION	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Extreme cold				
Extreme heat				
Wetness				
High humidity				
Noise				
Chemicals				
Solvents/cleaners				
Soldering fluxes				
Cigarette smoke				
Perfumes				
Fumes, odors, dusts, gases				
List other irritants or allergens:				
Hazards (machinery, heights, etc.)				

MENTAL RESIDUAL FUNCTIONAL CAPACITY

	I. MENTAL ABILITIES AND APTITUDES NEEDED TO DO UNSKILLED WORK	Unlimited or Very Good	Limited but satisfactory	Seriously limited, but not precluded	Unable to meet competitive standards	No useful ability to function
	Remember work-like procedures					
	Understand and remember very short and simple instructions					
	Carry out very short and simple instructions					
	Maintain attention for two hour segment					
	Maintain regular attendance and be punctual within customary, usually strict tolerances					
	Sustain an ordinary routine without special supervision					
	Work in coordination with or proximity to others without being unduly distracted					
	Make simple work-related decisions					
	Complete a normal workday and workweek without interruptions from psychologically based symptoms					
	Perform at a consistent pace without an unreasonable number and length of rest periods					
	Ask simple questions or request assistance					
	Accept instructions and respond appropriately to criticism from supervisors					
	Get along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes					
	Respond appropriately to changes in a routine work setting					
	Deal with normal work stress					
	Be aware of normal hazards and take appropriate precautions					

	II. MENTAL ABILITIES AND APTITUDES NEEDED TO DO SEMISKILLED AND SKILLED WORK	Unlimited or Very Good	Limited but satisfactory	Seriously limited, but not precluded	Unable to meet competitive standards	No useful ability to function
	Understand and remember detailed instructions					
	Carry out detailed instructions					
	Set realistic goals or make plans independently of others					
	Deal with stress of semiskilled and skilled work					

If stress tolerance is an issue, what demands of work do you find stressful?

- | | |
|--|---|
| <input type="checkbox"/> speed | <input type="checkbox"/> being criticized by supervisors |
| <input type="checkbox"/> precision | <input type="checkbox"/> simply knowing that work is supervised |
| <input type="checkbox"/> complexity | <input type="checkbox"/> getting to work regularly |
| <input type="checkbox"/> deadlines | <input type="checkbox"/> remaining at work for a full day |
| <input type="checkbox"/> working within a schedule | <input type="checkbox"/> fear of failure at work |

- | | |
|--|---|
| <input type="checkbox"/> making decisions | <input type="checkbox"/> monotony of routine |
| <input type="checkbox"/> exercising independent judgment | <input type="checkbox"/> little latitude for decision-making |
| <input type="checkbox"/> completing tasks | <input type="checkbox"/> lack of collaboration on the job |
| <input type="checkbox"/> working with other people | <input type="checkbox"/> no opportunity for learning new things |
| <input type="checkbox"/> dealing with the public (strangers) | <input type="checkbox"/> underutilization of skills |
| <input type="checkbox"/> dealing with supervisors | <input type="checkbox"/> lack of meaningfulness of work |

LITIGATION AND OTHER DETAILS (Include Attorney's Name, Address & Telephone)

WORKER'S COMPENSATION: _____

INSURANCE AND PENSION: _____

OTHER CLAIMS FOR BENEFITS: _____
