

County of Residence: _____

INITIAL INTERVIEW

Initial Contact _____ Appoint Date/Time _____

Name _____ Referred by: _____

Address: _____ Date of Birth _____

_____ SSN. _____

Phone No. _____ Education _____ Spec Ed: _____

Cell # _____ Last School Att: _____ Year _____

Marital Status _____ City/State Born: _____

Spouse Name _____ Mother's Maiden Name _____

Minor Children: _____ Stage of Claim _____

Type of Claim: DIB SSI Concurrent DWB DAC Child SSI CDI

Date of App: _____ Date Last Insured: _____ Date of Onset: _____

PIA: _____ Prior Application _____

Prior Representative _____

Military Disability: _____% Pension: _____

W/C: _____/Settled: _____ STD/LTD _____

Unemployment: _____ Began: _____ Ended: _____ Amount: _____

Spouses Income: _____

Contact Information: _____

Disabilities: _____

Miscellaneous Information _____

1 _____

2 _____

3 _____

4 _____

5 _____

Client _____ SSN: _____

Work History: _____

Alcohol/Drug/Criminal Record: _____

Incarcerations: _____

Outstanding Fines/Warrants/Fees/Probation: _____

Treating Physicians:

_____	1 st Visit _____	Last Visit _____	Next Visit: _____	Reason: _____
_____	1 st Visit _____	Last Visit _____	Next Visit: _____	Reason: _____
_____	1 st Visit _____	Last Visit _____	Next Visit: _____	Reason: _____
_____	1 st Visit _____	Last Visit _____	Next Visit: _____	Reason: _____
_____	1 st Visit _____	Last Visit _____	Next Visit: _____	Reason: _____
_____	1 st Visit _____	Last Visit _____	Next Visit: _____	Reason: _____

Hospitals:

_____	Date _____	Inpatient _____	Outpatient: _____	E/R: _____
_____	Date _____	Inpatient _____	Outpatient: _____	E/R: _____
_____	Date _____	Inpatient _____	Outpatient: _____	E/R: _____
_____	Date _____	Inpatient _____	Outpatient: _____	E/R: _____
_____	Date _____	Inpatient _____	Outpatient: _____	E/R: _____

Miscellaneous Information: _____
