KUSHNER & KUSHNER ATTORNEYS

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Appointment Date: _____
Appointment Time: _____
Interviewed by: _____

Jeffrey Kushner
Roberta Kushner
Jonas H. Kushner
Karen L. Nixon
Jason D. Quick

Have you had the following illness in the last 12 month?
If so, please notify our office.

____ **MRSA** **When:** _____
____ **TB** **When:** _____
____ **Infectious Disease** **When:** _____

SOCIAL SECURITY CLAIM INTERVIEW INFORMATION

DATE: _____

Referred by: _____ Current Client's Name
_____ Friend's Name
_____ Former Client's Name
_____ Television Commercial
_____ Saw in (Name of Publication)
_____ K&K Website
_____ Doctor's Name
_____ Attorney's Name
_____ Other (Explain)

PERSONAL HISTORY:

Name: _____
Social Security Number: _____ Date of Birth: _____ Age _____
_____ Male _____ Female Weight _____ Height _____

Mailing Address: _____

City, State & Zip: _____ (___ Own ____Rent)

City/State of Birth _____

Mother's Maiden Name: _____

Physical Address: _____
(If different from mailing address)
City, State & Zip _____

Home Phone: _____ Cell Phone: _____ Fax: _____
E-mail Address: _____

Spouse's Name: _____ Spouse's Maiden Name: _____
Spouse's SSN: _____ Spouse's DOB: _____
_____ Divorced _____ Married _____ Separated _____ Single
_____ Widowed - Spouses's Date of Death _____ Place of Marriage: _____

Previous Marriages: _____ Date of Dissolution

Children: _____ Yes _____ No If yes, please give names and ages of children:

_____, _____, _____
_____, _____, _____
If children are minors, are they in your custody: _____ Yes _____ No
Child support obligation: _____

EDUCATION

Highest Grade Completed: _____ Grades Repeated: _____ GED: ____Yes ____ No
Year of Graduation: _____
Can you read? _____ English _____ Spanish _____ Other
Can you write? _____ English _____ Spanish _____ Other
Add/Subtract? _____ Yes _____ No Multiply/Divide? _____ Yes _____ No
Can you make change? _____ Yes _____ No
Special or Vocational Training: _____ Yes _____ Vocational Rehab: _____ Yes _____ No
If yes, type of training: _____

MILITARY SERVICE

___ Yes ___ No If yes, dates: _____ Branch: _____ Special Military
Training: _____ Type of Discharge: _____ VA Rating: _____

PERSONAL INJURY ACCIDENTS

Any accidents (car accident, slip & fall, dog bite or other within the last 5years? ___Yes ___No
If yes, date(s): _____ Attorney: _____
IF YOU NEED REPRESENTATION, KUSHNER & KUSHNER CAN HELP YOU WITH YOUR ACCIDENT CASE

WORKER'S COMPENSATION

Do you have a claim for Worker's Compensation? _____ Yes _____ No
If yes, date of accident: _____ Attorney's Name: _____
IF YOU NEED REPRESENTATION, KUSHNER & KUSHNER CAN REFER YOU TO AN ATTORNEY.

Benefit Amount: $ _____ Weekly _____ Bi-weekly _____ Monthly _____
Has case been settled ? ____Yes ____No If yes, Date: _____ Amount: _____
If case settled, please bring copy of settlement agreement.

PRIVATE DISABILITY

Have you made a claim for Short Term or Long Term Disability through a private insurance company (i.e. UNUM, Aetna, etc)? _____ Yes _____ No

IF YOU NEED REPRESENTATION, KUSHNER & KUSHNER CAN HELP YOU WITH YOUR CASE.

WORK HISTORY (LAST 15 YEARS) Please start with the most recent job. Please include any work attempts since your onset of disability. Please bring copy of resume if available.

1. EMPLOYER _____ Job Title _____
   Address: _____
   Years employed: _____ Start Date: _____ End Date: _____
   Job Description: _____ Reason for Stopping: _____

2. EMPLOYER _____ Job Title _____
   Address: _____
   Years employed: _____ Start Date: _____ End Date: _____
   Job Description: _____ Reason for Stopping: _____

3. EMPLOYER _____ Job Title _____
   Address: _____
   Years employed: _____ Start Date: _____ End Date: _____
   Job Description: _____ Reason for Stopping: _____

MEDICAL PROBLEMS

1. _____ 2. _____ 3. _____

4. _____ 5. _____ 6. _____

7. _____ 8. _____ 9. _____

Limitation(s) imposed by treating doctor(s): _____

MEDICAL TREATMENT (DOCTORS, HOSPITALIZATIONS, MENTAL HEALTH TREATMENT (Please attach business cards if available)

Name: _____
Address: _____
Phone: _____
Conditions treated for: _____
Dates of Treatment: Start _____ Stop: _____

Name: _____
Address: _____
Phone: _____
Conditions treated for: _____
Dates of Treatment: Start _____ Stop: _____

Name: _____
Address: _____
Phone: _____
Conditions treated for: _____
Dates of Treatment: Start _____ Stop: _____

MEDICATIONS

	Drug/Dosage	Reason/Condition	Doctor	How Long	Side Effects
1.					
2.					
3.					
4.					
5.					
6.					

MONTHLY INCOME Do you or your spouse receive any of the following? If so, please provide the amounts.

	YOU	SPOUSE
Social Security	$_____	$_____
Unemployment	$_____	$_____
Workers's Compensation	$_____	$_____
Private Pension	$_____	$_____
Short Term Disability	$_____	$_____
Long Term Disability	$_____	$_____
V.A. Pension	$_____	$_____
R.R. Retirement	$_____	$_____
Government Pension	$_____	$_____
Welfare/Food Stamps	$_____	$_____
Earned Income	$_____	$_____
Other	$_____	$_____

Bank Account Information or please provided voided check (required by SSA).
Account Number: _____ Routing Number: _____

1. Relative/Friend Name: _____
   Address: _____
   City, State, Zip: _____
   Phone: _____

2. Relative/Friend Name: _____
   Address: _____
   City, State, Zip: _____
   Phone: _____

3. Relative/Friend Name: _____
   Address: _____
   City, State, Zip: _____
   Phone: _____

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SOCIAL SECURITY CLAIM INTERVIEW INFORMATION

FUNCTIONAL CAPACITY

How long can you sit? _____ Stand?_____
How far can you walk?_____ Can you bend? _____ Yes _____ No
Can you kneel? _____ Yes _____ No Can you crawl? _____ Yes _____ No
Can you stoop? _____Yes _____ No Can you climb? _____ Yes _____ No
How many pounds can you lift? _____
Can you reach over your head? _____ Yes _____ No

EMOTIONAL/SOCIAL HISTORY

	CONSTANTLY	FREQUENTLY	OCCASIONALLY	RARELY	NEVER
Nervous					
Tense/Shaky					
Irritable					
Depressed/Tearful					
Anxious/Fearful					
Stay by self					
Short-tempered					
Easily change moods					
Usually tired/weak					
Lose interest in doing things					
Do not like crowds					
Do not like socializing					
Memory difficulties					
Difficulty dealing with stress					
Suicidal thoughts					
Visions					
Drink Alcohol					
Smoke					

Are you presently able to:

	YES	NO	LIMITATIONS/HOW OFTEN
Drive a car	____	____	_____
Take a daily bath/shower	____	____	_____
Get dressed everyday	____	____	_____
Fix your own meals	____	____	_____
Do dusting/cleaning	____	____	_____
Wash dishes	____	____	_____
Grocery shopping	____	____	_____
Go to church	____	____	_____
Go out to dinner or movies	____	____	_____
Visit friends/relatives	____	____	_____
Watch T.V.	____	____	_____
Do yard work	____	____	_____
Handle finances	____	____	_____

Do you or have you ever done the following:

Drink alcohol _____ Yes _____ No
Smoke _____ Yes _____ No
Use drugs _____ Yes _____ No

****

OFFICE USE ONLY. PLEASE DO NOT COMPLETE.

Application date: _____ SS Office of application filing: _____

Type of claim: _____ DIB _____ SSI _____ Widow's _____ Child _____ Term.

Current status: _____

Prior applications: _____

Date last worked: _____ Onset of disability: _____ DLI px: _____