Disability Client Intake Form

Name: _____ DOB: _____

Address: _____ Email: _____

_____

_____ Phone: _____

Emergency contact _____ SSN#: _____

Highest Level of Education: _____

How did you hear about our firm: _____

Health Conditions

Please list all of your health conditions in order from the condition that causes you the most limitations from being able to work to the least.

1. _____ 5. _____

2. _____ 6. _____

3. _____ 7. _____

4. _____ 8. _____

Work History

Please list your work history over the last 15 years.

Job Title	Date Ranges at this job (Month/year)	Hours (Full or part time) & Wages

Current Medications

Medication	Reason for taking	Prescribing Doctor

Healthcare Providers

Please list all of your healthcare providers you have treated with over the last two (2) years including but not limited to Hospitals, Primary Physicians, Specialists, Pain Clinics, Psychologists, Psychiatrists, Therapists, Counselors, Physical Therapy, Occupational Therapy, Substance Abuse Treatment, Diagnostic Studies (MRI's, X-rays, EMG's, EKG's, etc...).

If you (or the claimant you are helping) was in special education classes in school, please also list the school info below as well.

Healthcare Provider	Address/contact information