

DEMPSEY, DEMPSEY & MOELLRING, P.C.

Attorneys at Law - Missouri & Illinois

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Katie L. Ambler

👉 Please complete the following and bring it with you to your appointment. You MUST have this completed in order to meet with the attorney.

Name: _____

Appointment Date: _____ Time: _____

Quincy Office

Hannibal Office

1) **Please bring your denial letter to your appointment;**

2) When was the last day you worked? ____ / ____ / ____

How many hours per week were you working when you quit? _____

If you were working part-time when you quit, when was the last date you worked full-time? ____ / ____ / ____

3) Where were you working and why did you quit?

4) Have you worked five out of the last ten years? Yes or No

5) Have you applied for Social Security Disability? Yes or No

If Yes, is your case still open? Yes or No

6) What date did you give to the Social Security Administration as the date you became disabled? ____ / ____ / ____

7) What are the illnesses, injuries, or conditions that limit your ability to work?

8) How do your illnesses, injuries, or conditions limit your ability to work?

9) Do you have health insurance? Yes or No
Do you have Medicaid? Yes or No

10) Your Height: _____ Your Weight: _____

11) **Please list the healthcare providers (mental and physical) you have seen. List ONLY the ones you have seen since you last completed paperwork for the Social Security Office;**

Name of Healthcare Provider: _____

Complete mailing address: Street or P.O. Box _____

City _____ State _____ Zip Code _____

Telephone Number: _____

Approximate Date you first saw this healthcare provider: _____

Approximate Date you last saw this healthcare provider: _____

Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: _____

What was the reason for your last visit to this healthcare provider? _____

What treatment was received ? _____

Name of Healthcare Provider: _____

Complete mailing address: Street or P.O. Box _____

City _____ State _____ Zip Code _____

Telephone Number: _____

Approximate Date you first saw this healthcare provider: _____

Approximate Date you last saw this healthcare provider: _____

Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: _____

What was the reason for your last visit to this healthcare provider? _____

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Name of Healthcare Provider: _____

Complete mailing address: Street or P.O. Box _____

City _____ State _____ Zip Code _____

Telephone Number: _____

Approximate Date you first saw this healthcare provider: _____

Approximate Date you last saw this healthcare provider: _____

Do you have another appointment scheduled to see this healthcare provider? If so, please list the date: _____

What was the reason for your last visit to this healthcare provider? _____

What treatment was received ? _____

14) How many years of education do you have? (High School = 12 years. If you have any college credit, indicate number of years and degree. If you have a GED, please include highest grade you completed before dropping out.)

15) Please name the last school you attended identifying town and state where it is located.

16) Were you in special education classes? Yes or No

17) Have you served in the military? If so, please identify the branch of service and what type of discharge you have.

18) Have you ever been convicted of a felony? If so please state the year and sentence for each offense.

19) Do you have children under the age of 18? If so, list for each

Name	Age	Social Security Number
1.		
2.		
3.		
4.		
5.		

20) What was the city and state of your birth? (Required to communicate with social security)

21) What is your mother's maiden name? (Required to communicate with social security)

22) Have any of your physicians or counselors suggested you have a problem with drugs or alcohol?

23) Have you ever applied for social security benefits *before*? If so, please state the year and whether or not you went to a hearing before a judge.

24) Are you married? Yes or No

If yes, does your spouse work? Yes or No.

If yes, does your spouse work full-time or part-time?

If part-time, how many hours per week does your spouse work and at what rate of pay? _____ hours at \$ _____/hour.

25) Do you have a pending workers compensation claim? Yes or No

26) **Your Work History**

Please list every job you have had in the past 15 years. Use more space if you need it.

A. Employer:

Job Title:

Years worked: ____/____/____ through ____/____/____

Job Description:

Amount of weight routinely lifted:

How much time standing:

How much time sitting:

B. Employer:

Job Title:

Years worked: ____/____/____ through ____/____/____

Job Description:

Amount of weight routinely lifted:

How much time standing:

How much time sitting:

C. Employer:

Job Title:

Years worked: ____/____/____ through ____/____/____

Job Description:

Amount of weight routinely lifted:

How much time standing:

How much time sitting:

(Please use back of this form to include ALL employers for past 15 years.)

27) Please list 2 people who know your condition(s) other than healthcare providers:

1) Name:	Relationship to you:
Address:	Phone #:
2) Name	Relationship to you:
Address:	Phone #:

28) Please list two people (who do not live with you or with each other) who will be able to help us find you, if we lose contact with you:

1) Name	Relationship to you:
Address:	Phone #:
2) Name	Relationship to you:
Address:	Phone#:

Thank you. We look forward to seeing you.

Medical Tests - Please select tests you have had (or expect to have).

Test Done or Will Be Done	Test	Most recent date done or expected to be done	Where was this done or where will it be done	Who sent you or will send you for this test	How many times has it been done
<input type="checkbox"/>	EKG (heart test)				
<input type="checkbox"/>	Treadmill (Exercise Test)				
<input type="checkbox"/>	Cardiac Catheterization				
<input type="checkbox"/>	Biopsy (What part) _____				
<input type="checkbox"/>	Hearing Test				
<input type="checkbox"/>	Vision Test				
<input type="checkbox"/>	IQ Test				
<input type="checkbox"/>	EEG (Brain Wave Test)				
<input type="checkbox"/>	HIV Test				
<input type="checkbox"/>	Blood Test				
<input type="checkbox"/>	Breathing Test				
<input type="checkbox"/>	X-Ray (What did you have Xray on) _____				
<input type="checkbox"/>	MRI-CT Scan _____ —				
<input type="checkbox"/>	Speech/Lang . Test				
<input type="checkbox"/>	Other				
<input type="checkbox"/>	Other				