NEW CLIENT INTAKE FORM

THANK YOU FOR CHOOSING THE DISABILITY REP FIRM

THE DISABILITY REP FIRM

6130 Elton Ave, Las Vegas, NV 89107
info@thedisabilityrepfirm.com
877-553-9337
Mon-Fri 9-5

MEET YOUR REPRESENTATIVE

Tressa Stevens-Haddock is a qualified Social Security disability representative and advocate, who has significant experience with the Social Security Administration's hearings process. Stevens-Haddock is a member of National Organization for Social Security Claimants' Representatives (NOSSCR). Stevens-Haddock is a passionate and knowledgeable advocate dedicated to helping individuals throughout the United States receive all the benefits they are entitled to under the law. Having worked for over six years with the agency as part of the hearings process, Stevens-Haddock gained insight into what is needed to successfully prepare for hearings and win cases.

Ms. Stevens-Haddock is prepared to be your voice before the Social Security Administration. She will represent you through each stage of the disability process, including a hearing before an Administrative Law Judge (ALJ), should it become necessary. Stevens-Haddock is available to meet with you for a free consultation.

INSTRUCTIONS TO ALL OF OUR CLIENTS

Please go to our website www.thedisabilityrepfirm.com and download the physical or mental questionnaire. Please give this questionnaire to your treating doctor and make sure it is returned to The Disability Rep Firm, it will increase your chance at getting a favorable decision.

BASIC INFORMATION

Referral source:	
Today's date:	
Do you have a current application pending?	(yes / no)
If so, when was your most recent denial date?	
Has an Appeal been filed?	(yes / no)
Full-name (First Middle, Last)	
What date did you first become disabled?	
Height and weight:	
Previous names (if applicable):	
Social Security Number:	
Phone #:	
E-mail (if applicable):	
Date of birth:	
Current age:	
Place of birth:	
What is your income:	
Mailing address:	
How long have you been living at your current address?	
Highest Grade Completed:	
Current Martial Status:	

CURRENT SPOUSE INFORMATION

Spouses Name:	
Married city/state:	
Date of Marriage:	
Spouse social security number:	
Spouse's income:	

CHILDREN THAT CURRENTLY LIVE WITH YOU UNDER AGE OF 18
(NAMES, AGE, AND SOCIAL SECURITY NUMBER.)

1	
2	
3	
4	

LIST YOUR CURRENT DIAGNOSED DISABILITIES

1	
2	
3	
4	
5	

RECENT SURGERIES WITHIN THE LAST 3 YRS (LIST SURGERIES)

1	
2	
3	

ALCOHOL AND DRUGS
(THE INFO THAT YOU PROVIDE WILL NOT BE USE AGAINST YOU)

How often do you drink alcohol?	
Do you use recreational drugs? Is so, what?	

VETERAN INFORMATION

Veteran?	yes / no
If so, do you have a VA disabilities rating to your service?	yes / no

JAIL / PRISON

Have you served time in jail or prison?	yes / no
If yes, what was if for?	

ADDITIONAL CONTACT

Name of secondary contact:	
What is their relationship to you:	
Phone # of secondary contact	

PREVIOUS MARRIAGES
(IF LASTED OVER 10YEARS BESIDE YOUR CURRENT MARRIAGE)

How many times have you been married? _____

1ST MARRIAGE

Name of ex-spouse:	yes / no
Current age or date of birth:	
Place of birth:	
Date of marriage:	
Date ended:	
Married where:	
If divorced, where did you get divorced?	

2ND MARRIAGE

Name of ex-spouse:	yes / no
Current age or date of birth:	
Place of birth:	
Date of marriage:	
Date ended:	
Married where:	
If divorced, where did you get divorced?	

WORK HISTORY GOING BACK 15-YEARS

FULL-TIME JOBS THAT LAST 3-MONTHS OR LONGER / YOU EARNED $1,080 A MONTH OR MORE.

#1 NAME OF EMPLOYER:

Did you work full-time? (Full- time is 32 hours a week or more.)	
Name of Employer	
Job title:	
Weekly Earning	Hourly pay: Salary pay:
Dates Employed	Start date: End date:
Please briefly describe your job duties:	

#2 NAME OF EMPLOYER:

Did you work full-time? (Full- time is 32 hours a week or more.)	
Name of Employer	
Job title:	
Weekly Earning	Hourly pay: Salary pay:
Dates Employed	Start date: End date:
Please briefly describe your job duties:	

#3 NAME OF EMPLOYER:

Did you work full-time? (Full- time is 32 hours a week or more.)	
Name of Employer	
Job title:	
Weekly Earning	Hourly pay: Salary pay:
Dates Employed	Start date: End date:
Please briefly describe your job duties:	

#4 NAME OF EMPLOYER:

Did you work full-time? (Full- time is 32 hours a week or more.)	
Name of Employer	
Job title:	
Weekly Earning	Hourly pay: Salary pay:
Dates Employed	Start date: End date:
Please briefly describe your job duties:	

#5 NAME OF EMPLOYER:

Did you work full-time? (Full- time is 32 hours a week or more.)	
Name of Employer	
Job title:	
Weekly Earning	Hourly pay: Salary pay:
Dates Employed	Start date: End date:
Please briefly describe your job duties:	

#6 NAME OF EMPLOYER:

Did you work full-time? (Full- time is 32 hours a week or more.)	
Name of Employer	
Job title:	
Weekly Earning	Hourly pay: Salary pay:
Dates Employed	Start date: End date:
Please briefly describe your job duties:	

ASSETS INFORMATION

IF YOU HAVE A CHECK/SAVINGS ACCOUNT, WE WILL NEED THE ACCOUNT INFORMATION. ONCE YOU ARE AWARDED YOUR BENEFITS, THE SOCIAL SECURITY OFFICE WILL DIRECT DEPOSIT YOUR CASH-BENEFITS. .

Do you have a bank account? (Please circle one)	yes / no
If so, what is your current balance?	
Savings Account? If so, what is your current balance?	yes / no
Vehicles registered in your name:	Car Make: Car Year: Car Value (estimate): Car Make: Car Year: Car Value (estimate):
Are you renting/currently own?	

LIST OF CURRENT DOCTORS

***IF YOU HAVE MORE DOCTORS, PLEASE LIST THEM UNDER REMARKS SECTION AT THE END OF THIS FORM.

#1 Name of Clinic/Hospital:	
Name of Doctor:	
Type of Doctor (ex. primary, cardiologist, psychiatrist, etc.):	
Address:	
Phone #:	
Fax # (if you have it):	
Date of first visit:	
Primary Reason for Doctor Visit	

#2 Name of Clinic/Hospital:	
Name of Doctor:	
Type of Doctor (ex. primary, cardiologist, psychiatrist, etc.):	
Address:	
Phone #:	
Fax # (if you have it):	
Date of first visit:	
Primary Reason for Doctor Visit	

#3 Name of Clinic/Hospital:	
Name of Doctor:	
Type of Doctor (ex. primary, cardiologist, psychiatrist, etc.):	
Address:	
Phone #:	
Fax # (if you have it):	
Date of first visit:	
Primary Reason for Doctor Visit	

#4 Name of Clinic/Hospital:	
Name of Doctor:	
Type of Doctor (ex. primary, cardiologist, psychiatrist, etc.):	
Address:	
Phone #:	
Fax # (if you have it):	
Date of first visit:	
Primary Reason for Doctor Visit	

LIST OF MEDICATIONS

(CURRENT MEDICATIONS)	(PRESCRIBING DOCTOR& REASON FOR TAKING MEDICATAION)
1.	Prescribing Doctor: Treating for:
2.	Prescribing Doctor: Treating for:
3.	Prescribing Doctor: Treating for:
4.	Prescribing Doctor: Treating for:
5.	Prescribing Doctor: Treating for:
6.	Prescribing Doctor: Treating for:
7.	Prescribing Doctor: Treating for:
8.	Prescribing Doctor: Treating for:
9.	Prescribing Doctor: Treating for:
10.	Prescribing Doctor: Treating for:

REMARKS SECTION

ANY ADDITIONAL COMMENTS

PLEASE HAVE THIS FORM READY FOR YOUR APPOINTMENT.
YOU MAY ALSO MAIL OR EMAIL THIS FORM TO:

MAILING:
THE DISABILITY REP FIRM
TRESSA M. STEVENS-HADDOCK
6130 ELTON AVE
LAS VEGAS NV 89107

EMAIL:
INFO@THEDISABILITYREPFIRM.COM

PHONE:
(877) 553-9337