DISABILITY INFORMATION

NAME: FIRST________________________ LAST___________________________________

AGE:_____ BIRTHDATE: _____________

MAILING ADDRESS: ________________________

CITY: _____________________ STATE: ___________ ZIP: __________

PHONE:_______________________ CELL PHONE: _____________________

DISABILITIES:____

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DATE OF LAST TREATMENT: ___________________ SURGERIES AND DATES:____________

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ARE YOU STILL WORKING?_________ DATE LAST WORKED_______________________

REFERRED BY:____

DATE APPLICATION FILED WITH SOCIAL SECURITY?______________DENIED?__________

1ST or 2nd DENIAL?_______________________DATE OF LAST DENIAL:___________________

HAVE YOU WORKED 5 OF THE LAST 10 YRS?______________________________________

IF NOT, LIST GROSS MONTHLY INCOME____

MINOR CHILDREN & AGES:____

NOTES:____

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