Disability Intake Form

Name:	Social Security #:
Address:	Date of Birth:
City, State, Zip Code:	Home Phone:
Email:	Work Phone:
Primary Physician:	Mobile Phone:
Psychiatrist:	Diagnosed Disability:
Date of Onset/Initial Diagnosis	Date you last worked:
Have you applied for SSI or SSDI: Date:	What is your job description:
Are you currently under the care of a doctor? ○ Yes ○ No	

The documentation I will submit verifies that I have the following disability: (Check all that apply)

☐	Learning Disability	☐	Autism Spectrum Disorder
☐	Attention Deficit Disorder (ADD)	☐	Traumatic Brain Injury (TBI)
☐	Psychological Impairment	☐	Neurological Disorder
☐	Physical/Mobility Impairment	☐	Lyme Disease
☐	Deaf/Hard of Hearing	☐	Schizophrenia/Psychosis
☐	Blind/Vision Impairment	☐	Communication/Speech Language
☐	Chronic Health Impairment	☐	Epilepsy
☐	HIV/AIDS	☐	Developmental Disability
☐	Respiratory/Pulmonary	☐	Cardiac/Circulatory
☐	Cancer	☐	Burn Injury
☐	Cerebral Palsy	☐	Stroke
☐	Muscular Dystrophy	☐	Hansen's Disease
☐	Multiple Sclerosis	☐	Huntington's Disease
☐	Arthritis	☐	Endocrine/Metabolic Disease
☐	Back Injury	☐	Dementia
☐	Other		

Insurance Information

Primary Insurance:	Policy Holder Name:
City, State, Zip Code:	Identification Number:
Employer:	Policy Holder SSN:

Please briefly describe your understanding of your current impairment and any relevant diagnosis.

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When were you first diagnosed with the condition you consider disabling? If more than one, list them separately.

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Describe how your impairment(s) impact(s) your functioning.

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When and by whom were you recently evaluated/treated for the condition(s) that cause your impairment?

When:____

By whom:____

Signature:____**Date:**_______________