SOCIAL SECURITY ADMINISTRATION

Form Approved
OMB No. 0960-0579

DISABILITY REPORT ADULT

For SSA Use Only- Do not write in this box.

Related SSN _____

Number Holder _____

If you are filling out this report for someone else, please provide information about him or her. When a question refers to "you" or "your," it refers to the person who is applying for disability benefits.

SECTION 1 - INFORMATION ABOUT THE DISABLED PERSON

1.A. Name (First, Middle Initial, Last)

1.B. Social Security Number

1.C. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (If not USA)

1.D. Email Address

1.E. Daytime Phone Number, including area code, and the IDD and country codes if you live outside the USA or Canada.

Phone number _____

☐ Check this box if you do not have a phone or a number where we can leave a message .

1.F. Alternate Phone Number - another number where we may reach you, if any.

Alternate phone number _____

1.G. Can you speak and understand English? ☐ YES ☐ NO

If no, what language do you prefer? _____

If you cannot speak and understand English, we will provide an interpreter, free of charge.

1.H. Can you read and understand English? ☐ YES ☐ NO

1.I. Can you write more than your name in English? ☐ YES ☐ NO

1.J. Have you used any other names on your medical or educational records? Examples are maiden name, other married name, or nickname. ☐ YES ☐ NO

If yes, please list them here:

SECTION 2 - CONTACTS

Give the name of someone **(other than your doctors)** we can contact who knows about your medical conditions, and can help you with your claim.

2.A. Name (First, Middle Initial, Last)

2.B. Relationship to you

2.C. Daytime Phone Number (as described in 1.E. above)

2.D. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (If not USA)

2. E. Can this person speak and understand English? ☐ YES ☐ NO

If no, what language is preferred? _____

SECTION 2 - CONTACTS (continued)

2.F. Who is completing this report?

- ☐ The person who is applying for disability. (Go to Section 3 - Medical Conditions)
- ☐ The person listed in 2.A. (Go to Section 3 - Medical Conditions)
- ☐ Someone else (Complete the rest of Section 2 below)

2.G. Name (First, Middle Initial, Last)	**2.H.** Relationship to Person Applying

2.I. Daytime Phone Number _____

2.J. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.

City	State/Province	ZIP/Postal Code	Country (If not USA)

SECTION 3 - MEDICAL CONDITIONS

3.A. List all of the physical or mental conditions (including emotional or learning problems) that limit your ability to work. If you have cancer, please include the stage and type. List each condition separately.

1.
2.
3.
4.
5.

If you need more space, go to Section 11-Remarks on the last page

3.B. What is your height without shoes? ____ feet ____ inches OR ____ centimeters (if outside USA)

3.C. What is your weight without shoes? ____ pounds OR ____ kilograms (if outside USA)

3.D. Do your conditions cause you pain or other symptoms? ☐ YES ☐ NO

SECTION 4 - WORK ACTIVITY

4.A. Are you currently working?

- ☐ No, I have never worked (Go to question **4.B.** below)
- ☐ No, I have stopped working (Go to question **4.C.** below)
- ☐ Yes, I am currently working (Go to question **4.F.** on page 3)

IF YOU HAVE NEVER WORKED:

4.B. When do you believe your condition(s) became severe enough to keep you from working (even though you have never worked)? (month/day/year) _____ (Go to Section 5 on page 3)

IF YOU HAVE STOPPED WORKING:

4.C. When did you stop working? (month/day/year) _____

Why did you stop working?

- ☐ Because of my condition(s).
- ☐ Because of other reasons. Please explain why you stopped working (for example: laid off, early retirement, seasonal work ended, business closed) _____

Even though you stopped working for other reasons, when do you believe your condition(s) became severe enough to keep you from working? (month/day/year) _____

4.D. Did your condition(s) cause you to make changes in your work activity? (for example: job duties, hours, or rate of pay)

- ☐ No (Go to Section 5 - Education and Training on page 3)
- ☐ Yes When did you make changes? (month/day/year) _____

SECTION 4 - WORK ACTIVITY (continued)

4.E. Since the date in 4.D. above, have you had gross earnings greater than $1,010 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ No (Go to Section 5) ☐ Yes (Go to Section 5)

IF YOU ARE CURRENTLY WORKING:

4.F. Has your condition(s) caused you to make changes in your work activity? (for example: job duties or hours)

☐ No When did your condition(s) first start bothering you? (month/day/year) _____

☐ Yes When did you make changes? (month/day/year) _____

4.G. Since your condition(s) first bothered you, have you had gross earnings greater than $1,010 in any month? Do not count sick leave, vacation, or disability pay. (We may contact you for more information.)

☐ NO ☐ YES

SECTION 5 - EDUCATION AND TRAINING

5.A. Check the highest grade of school completed. College:

0	1	2	3	4	5	6	7	8	9	10	11	12	GED	1	2	3	4 or more
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Date completed: _____

5.B. Did you attend special education classes? ☐ YES ☐ NO (Go to 5.C.)

Name of School _____

City _____ State/Province _____ Country (If not USA) _____

Dates attended special education classes: from _____ to _____

5.C. Have you completed any type of specialized job training, trade, or vocational school?

☐ YES ☐ NO

If "Yes," what type? _____ Date completed: _____

If you need to list other education or training use Section 11 - Remarks on the last page.

SECTION 6 - JOB HISTORY

6.A. List the jobs (up to 5) that you have had in the 15 years before you became unable to work because of your physical or mental conditions. List your most recent job first.

☐ Check here and go to Section 7 on page 5 if you did not work at all in the 15 years before you became unable to work.

Job Title	Type of Business	Dates Worked		Hours Per Day	Days Per Week	Rate of Pay	
		From MM/YY	To MM/YY			Amount	Frequency
1.							
2.							
3.							
4.							
5.							

SECTION 6 - JOB HISTORY (continued)

Check the box below that applies to you.

☐ I had **only one job** in the last 15 years before I became unable to work. Answer the questions below.

☐ I had **more than one job** in the last 15 years before I became unable to work. Do **not** answer the questions on this page; go to Section 7 on page 5. (We may contact you for more information.)

Do not complete this page if you had **more than one job** in the last 15 years before you became unable to work.

6.B. Describe this job. What did you do all day? _____

_____

_____

(If you need more space, use Section 11 - Remarks on the last page.)

6.C. In this job, did you:

Use machines, tools or equipment? ☐ YES ☐ NO

Use technical knowledge or skills? ☐ YES ☐ NO

Do any writing, complete reports, or perform any duties like this? ☐ YES ☐ NO

6.D. In this job, how many total hours each day did you do each of the tasks listed:

Task	Hours	Task	Hours	Task	Hours
Walk		Stoop *(Bend down & forward at waist.)*		Handle large objects	
Stand		Kneel *(Bend legs to rest on knees.)*		Write, type, or handle small objects	
Sit		Crouch *(Bend legs & back down & forward.)*		Reach	
Climb		Crawl *(Move on hands & knees.)*			

6.E. Lifting and carrying *(Explain in the box below, what you lifted, how far you carried it, and how often you did this in your job.)* _____

_____

_____

6.F. Check **heaviest** weight lifted:

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ Other _____

6.G. Check weight **frequently** lifted: *(by frequently, we mean from 1/3 to 2/3 of the workday.)*

☐ Less than 10 lbs. ☐ 10 lbs. ☐ 25 lbs. ☐ 50 lbs. or more ☐ Other _____

6.H. Did you supervise other people in this job? ☐ YES (Complete items below.) ☐ NO (if No, go to **6.I.**)

How many people did you supervise? _____

What part of your time did you spend supervising people? _____

Did you hire and fire employees? ☐ YES ☐ NO

6.I. Were you a lead worker? ☐ YES ☐ NO

SECTION 7 - MEDICINES

7. Are you taking any medicines (prescription or non-prescription)?

☐ YES (Give the information requested below. You may need to look at your medicine containers.)

☐ NO (GotoSection8-MedicalTreatment.)

Name of Medicine	If prescribed, give name of doctor	Reason for medicine

If you need to list other medicines, go to Section 11 - Remarks on the last page.

SECTION 8 - MEDICAL TREATMENT

Have you seen a doctor or other health care professional or received treatment at a hospital or clinic, or **do you have a future appointment scheduled?**

8.A. For any **physical** condition(s)?

☐ YES ☐ NO

8.B. For any **mental** condition(s) **(including emotional or learning problems)**?

☐ YES ☐ NO

If you answered "No" to both 8.A. and 8.B., go to Section 9 - Other Medical Information on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.C. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	2. Emergency Room visits List the most recent date first	3. Overnight hospital stays List the most recent date first
First Visit _____	A. _____	A. Date in _____ Date out _____
Last Visit _____	B. _____	B. Date in _____ Date out _____
Next scheduled appointment (if any) _____	C. _____	C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Check the boxes below for any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests,use Section 11-Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part) _____		☐ X-Ray (list body part) _____	
☐ Hearing Test		☐ MRI/CT Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

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Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	2. Emergency Room visits	3. Overnight hospital stays
First Visit	List the most recent date first	List the most recent date first
Last Visit	A.	A. Date in Date out
Next scheduled appointment (if any)	B.	B. Date in Date out
	C.	C. Date in Date out

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

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☐ Biopsy (list body part)		☐ X-Ray (list body part)	
☐ Hearing Test		☐ MRI/CT Scan (list body part)	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe)	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.E. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits
First Visit _____
Last Visit _____
Next scheduled appointment (if any) _____

2. Emergency Room visits
List the most recent date first
A. _____
B. _____
C. _____

3. Overnight hospital stays
List the most recent date first
A. Date in _____ Date out _____
B. Date in _____ Date out _____
C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

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☐ Biopsy (list body part) _____		☐ X-Ray (list body part) _____	
☐ Hearing Test		☐ MRI/CT Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.F. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	**2. Emergency Room visits** List the most recent date first	**3. Overnight hospital stays** List the most recent date first
First Visit _____	A. _____	A. Date in _____ Date out _____
Last Visit _____	B. _____	B. Date in _____ Date out _____
Next scheduled appointment (if any) _____	C. _____	C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
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☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part) _____		☐ X-Ray (list body part) _____	
☐ Hearing Test		☐ MRI/CT Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you do not have any more doctors or hospitals to describe, go to Section 9 on page 11.

SECTION 8 - MEDICAL TREATMENT (continued)

Tell us who may have medical records about any of your **physical and/or mental** condition(s) (including emotional or learning problems) that limit your ability to work. This includes doctors' offices, hospitals **(including emergency room visits)**, clinics, and other health care facilities. Tell us about your next appointment, if you have one scheduled.

8.G. Name of Facility or Office	Name of health care professional who treated you

ALL OF THE QUESTIONS ON THIS PAGE REFER TO THE HEALTH CARE PROVIDER ABOVE.

Phone Number	Patient ID# (if known)

Mailing Address

City	State/Province	ZIP/Postal Code	Country (If not USA)

Dates of Treatment

1. Office, Clinic or Outpatient visits	2. Emergency Room visits	3. Overnight hospital stays
First Visit _____	List the most recent date first	List the most recent date first
Last Visit _____	A. _____	A . Date in _____ Date out _____
Next scheduled appointment (if any) _____	B. _____	B. Date in _____ Date out _____
	C. _____	C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

What treatment did you receive for the above conditions? (Do not describe medicines or tests in this box.)

Tell us about any tests this provider performed or sent you to, or has scheduled you to take. Please give the dates for past and future tests. If you need to list more tests, use Section 11 - Remarks on the last page.

☐ **Check this box if no tests by this provider or at this facility.**

Kind of Test	Dates of Tests	Kind of Test	Dates of Tests
☐ EKG (heart test)		☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☐ Biopsy (list body part) _____		☐ X-Ray (list body part) _____	
☐ Hearing Test		☐ MRI/CT Scan (list body part) _____	
☐ Speech/Language Test			
☐ Vision Test		☐ Other (please describe) _____	
☐ Breathing Test			

If you have been treated by more than five doctors or hospitals, use Section 11 - Remarks on the last page and give the same detailed information as above for each healthcare provider.

SECTION 9 - OTHER MEDICAL INFORMATION

9. Does **anyone else** have medical information about your physical and/or mental condition(s) (including emotional and learning problems), or are you scheduled to see anyone else? (This may include places such as workers' compensation, vocational rehabilitation, insurance companies who have paid you disability benefits, prisons, attorneys, social service agencies and welfare.)

☐ YES (Please complete the information below.)

☐ NO (If you are receiving Supplemental Security Income (SSI) and have been asked to complete this report, go to Section 10 - Vocational Rehabilitation; if not, go to Section 11 on the last page.)

Name of Organization	Phone Number

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

Name of Contact Person	Claim or ID number (if any)

Date of First Contact	Date of Last Contact	Date of Next Contact (if any)

Reasons for Contacts

If you need to list other people or organizations use Section 11 - Remarks on the last page and give the same detailed information as above for each one you list.

COMPLETE THIS SECTION ONLY IF YOU ARE ALREADY RECEIVING SSI.
SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES

10.A. Have you participated, or are you participating in:

- An individual work plan with n employment network under the Ticket to Work Program;
- An individualized plan for employment with a vocational rehabilitation agency or any other organization;
- A Plan to Achieve Self-Support (PASS);
- An Individualized Education Program (IEP) through a school (if a student age 18-21); or
- Any program providing vocational rehabilitation, employment services, or other support services to help you go to work?

☐ YES (Complete the following information) ☐ NO (Go to Section 11)

10.B. Name of Organization or School

Name of Counselor, Instructor, or Job Coach	Phone Number

Mailing Address

City	State/Province	ZIP/Postal Code	Country (if not USA)

10.C. When did you start participating in the plan or program? _____

SECTION 10 - VOCATIONAL REHABILITATION, EMPLOYMENT, OR OTHER SUPPORT SERVICES (continued)

10.D. Are you still participating in the plan or program?

☐ YES, I am scheduled to complete the plan or program on: _____

☐ **NO.** I completed the plan or program on: _____

☐ **NO.** I stopped participating in the plan or program before completing it because:

_____

_____

_____

10.E. List the types of services, tests, or evaluations that you received (for example: intelligence or psychological testing, vision or hearing test, physical exam, work evaluations, or classes).

_____

_____

_____

If you need to list another plan or program use Section 11 - Remarks and give the same detailed information as above.

SECTION 11 - REMARKS

Please write any additional information you did not give in earlier parts of this report. If you did not have enough space in the sections of this report to write the requested information, please use this space to tell us the additional information requested in those sections. Be sure to show the section to which you are referring.

_____

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Date Report Completed	___/___/___ month, day, year