

Client Information and Intake Form

Personal Information/Intake	ERISA Claim	Soc. Sec. Claim	Other
Name	_____		
Soc. Sec. #	_____	Date of Birth	_____
Address	_____		
City/State/Zip	_____		
Home Phone	_____	Cell Phone	_____
# of dependants	_____	Place of Birth	_____
			(City/State)
Married?	Yes No	Spouse Working?	Yes No
Alternative Contact	_____		Phone _____

Work History/Background			
Most Recent Employer	_____	Job/Position	_____
Date Last Worked	_____	Hrly Wage/ Yrly Salary	\$ _____
	(date last actively worked)		
Terminated or Resigned	Terminated Resigned	End Date	_____
			(date last recorded as employee)
Previous Employer	_____	Job/Position	_____
Previous Employer	_____	Job/Position	_____
Previous Employer	_____	Job/Position	_____

Educational Background			
Highest Grade Finished	_____	School Sys.	_____
			(town or county and state)
Special Ed.	Y / N	GED.	Y / N
Vocational Training	Y / N	Technical Area	_____
			(field/license)

Conditions, Symptoms and Impairments

Medical Conditions

Resulting Symptoms/Impairments

Doctors/Clinics

Current P.C.P. _____

Prior P.C.P. _____

Address _____

Address _____

City/Zip _____

City/Zip _____

Period of Treatment _____

Period of Treatment _____

Phone # _____

Phone # _____

Current Specialist _____

Other Doctor/Specialist _____

Address _____

Address _____

City/Zip _____

City/Zip _____

Period of Treatment _____

Period of Treatment _____

Phone # _____

Phone # _____

Other Doctor/Specialist _____

Other Doctor/Specialist _____

Address _____

Address _____

City/Zip _____

City/Zip _____

Period of Treatment _____

Period of Treatment _____

Phone # _____

Phone # _____

Hospitalizations/Emergency Room Visits

Hospital _____

Hospital _____

City/ _____

City/ _____

Reason _____

Reason _____

Aprox. Dates; _____

Aprox. Dates; _____

Hospital _____

Hospital _____

City/ _____

City/ _____

Reason _____	Reason _____
Aprox. Dates: _____	Aprox. Dates: _____
Your Pharmacy: _____	Case Worker _____ (if any)
City/ _____	Agency _____
Phone # _____	Phone # _____

ERISA Claim Status

Insurance Company _____	Need help preparing application
Address _____	Need help with Administrative appeal
City/State/Zip _____	Need to file a lawsuit
Claim # _____	Uncertain of status

Social Security Claim Status

Need help filing a claim
Need to appeal first denial
Need to appeal denial at "reconsideration"
Need to file for an Administrative Law Judge Hearing
Uncertain of status

Additional Comments

Please add any additional comments or information that you think might be relevant or helpful to your case.
