SOCIAL SECURITY COUNSELING CENTER™
A Service of The Weisberg Law Group, PLLC

Child Questionnaire and Disability Report Information
Please answer EACH question completely

**Please complete this questionnaire on your child's behalf*

Applicant Information

Child's Full Name: **Parent/Guardian's Name:** _____

Other Names Used (child): _____

Social Security #: _____ Birthdate: _____

Street Address: _____

City: _____ State: _____ Zip: _____

Phone #: _____ Alternate Phone # (with a/c): _____

How did you hear about the ***Social Security Counseling Center?***

- ☐ Ford/UNICARE
- ☐ GM
- ☐ Alzheimer's Association
- ☐ CMH
- ☐ CNS
- ☐ Easter Seals
- ☐ Facebook
- ☐ Gilda's Club
- ☐ HFHS
- ☐ Karmanos
- ☐ Michigan/Oakland State Bar
- ☐ M.I.N.D.
- ☐ MS support Group
- ☐ Online
- ☐ Pamphlet in Dr. _____ office
- ☐ Providence Hospital
- ☐ Social worker, if *yes*, name and phone (with a/c): _____
- ☐ Former Client, if *yes*, name and phone (with a/c): _____
- ☐ Attorney referral, if *yes*, name and phone (with a/c): _____
- ☐ Other: _____

Is your child legally blind? ☐ Yes ☐ No

Other Social Security Numbers & Names

Has your child used any other Social Security Numbers? ☐ Yes ☐ No If *yes*, ___ ___ ___ - ___ ___ - ___ ___ ___ ___

*What is your child's Mother's maiden name (*required*)? _____

Has your child been denied for SSI in the last 60 days? ☐ Yes ☐ No

What was the date of your child's most recent denial for SSI? ____/____/_____ (mm/dd/yyyy)

What was the date of your child's most recent hearing in front of an Administrative Law Judge? ____/____/_____

Did you file a tax return LAST year? ☐ Yes ☐ No How much did you earn? _____

Will you file a tax return THIS year? ☐ Yes ☐ No How much did you earn? _____

Are you currently working or have you recently attempted to work? ☐ Yes ☐ No

If yes, please describe the type of work, number of hours worked, and amount of your wages:

_____

_____

Child's Emergency Contact (friend or relative other than yourself):

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone (with a/c): _____

Relationship: _____

Your Marital Status: ☐ Widowed ☐ Married ☐ Separated ☐ Divorced ☐ Never been married

Benefit Information

Have you recently applied for?			Date (mm/dd/yyyy)	Amount
Social Security Retirement	☐ Yes	☐ No		
State Disability Assistance	☐ Yes	☐ No		
Veteran's Benefits	☐ Yes	☐ No		
Workers' Compensation	☐ Yes	☐ No		
Personal Injury Law Suit	☐ Yes	☐ No		
Medicare	☐ Yes	☐ No		
Unemployment	☐ Yes	☐ No		
Supplemental Security Income	☐ Yes	☐ No		

Disability Information: Medical

Conditions

List the physical and mental conditions for which your child is **CURRENTLY** being treated:

1.	2.
3.	4.
5.	6.
7.	8.

Doctors and Other Healthcare Professionals

Primary/Family Doctor/Pediatrician:

Pediatrician's Name: _____ ☐ M.D. ☐ D.O.

Phone # (with a/c): _____

Address: _____

City: _____ State: _____ Zip: _____

Is your child still treating with this doctor? ☐ Yes ☐ No

Why does your child see this doctor? _____

First Appointment (month/year): _____ Last Appointment (month/year): _____

Medications: _____

_____

Tests ordered by this doctor and when: _____

Specialist/Specialty #1:

Doctor's Name: _____ ☐ M.D. ☐ D.O.

Phone # (with a/c): _____

Address: _____

City: _____ State: _____ Zip: _____

Is your child still treating with this doctor? ☐ Yes ☐ No

Why does your child see this doctor? _____

First Appointment (month/year): _____ Last Appointment (month/year): _____

Medications: _____

_____

Tests ordered by this doctor and when: _____

Specialist/Specialty #2:

Doctor's Name: _____ ☐ M.D. ☐ D.O.

Phone # (with a/c): _____

Address: _____

City: _____ State: _____ Zip: _____

Is your child still treating with this doctor? ☐ Yes ☐ No

Why does your child see this doctor? _____

First Appointment (month/year): _____ Last Appointment (month/year): _____

Medications: _____

_____

Tests ordered by this doctor and when: _____

Current Mental Health Facility:

Why does your child see this doctor? ______________________________

Facility Name: ______________________ Phone # (with a/c): ______________

Psychiatrist's Name: ______________________________

Therapist's Name: ______________________ ☐ NCPsyA ☐ MA ☐ LCP ☐ LCSW

Case Worker: ______________________________

Address: ______________________________

City: ______________________ State: __________ Zip: __________

First Appointment (month/year): __________ Last Appointment (month/year): __________

Medications: ______________________________

____

Hospitals & Clinics:

Please write let us know about each hospital that has treated your child in the last 2 years.

Address and Telephone Number	Why did your child go to this hospital?	Treatment Dates (month/year)
(Name of Hospital/Urgent Care Facility) (Telephone # w/ac) (Street Address) (City) (State) (Zip)		(Emergency Room) (Inpatient/Hospitalized) (Outpatient)
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School Information

Please list your child's current and previous school information.

	Name	Address	Start Date (month/year)	End Date (month/year)	Special Ed?
Current School		Street: City:			Yes ☐ No ☐
Previous School		Street: City:			Yes ☐ No ☐
Previous School		Street: City:			Yes ☐ No ☐
Previous School		Street: City:			Yes ☐ No ☐

Has your child had child had any psychological/IQ testing or evaluations? ☐ Yes ☐ No
If so when: ____/____/_____ (mm/dd/yyyy)

Has your child had an I. E. P.? ☐ Yes ☐ No
If so when: ____/____/_____ (mm/dd/yyyy)

Submit

We understand this is hard to do, so thank you.
Return this to us within 10 days along with the required signed forms.