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): William I. Hamilton

1.B. Social Security Number: 999-99-9999

1.C. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.
P.O. Box 24007

City	State/Province	ZIP/Postal Code	Country (If not USA)
Chicago	IL	60681	

1.D. Email Address: WIH@yahoo.com

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

Phone number: 515-123-4567

☐ 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: 515-123-5678

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): Payne, Mildred

2.B. Relationship to you: Cousin

2.C. Daytime Phone Number (as described in 1.E. above)
515-123-6789

2.D. Mailing Address (Street or P O Box) Include apartment number or unit if applicable.
456 Center Street, # 112

City	State/Province	ZIP/Postal Code	Country (If not USA)
Chicago	IL	60692	

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?

- [X] 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.	Arthritis right shoulder
2.	Liver problems (cirrhosis)
3.	Cataracts
4.	Nervous
5.	Back pain

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

3.B. What is your height without shoes? 5 feet 10 inches OR _____ centimeters (if outside USA)

3.C. What is your weight without shoes? 175 pounds OR _____ kilograms (if outside USA)

3.D. Do your conditions cause you pain or other symptoms? [X] YES [ ] NO

SECTION 4 - WORK ACTIVITY

4.A. Are you currently working?

- [ ] No, I have never worked (Go to question **4.B.** below)
- [X] 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) 10/12/2010

Why did you stop working?

- [X] 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)
- [X] Yes When did you make changes? (month/day/year) 5/8/2009

SECTION 4 - WORK ACTIVITY (continued)

4.E. Since the date in 4.D. above, have you had gross earnings greater than $980 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 $980 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: June, 1980

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? Electrician helper Date completed: 1983

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. Electrician Helper	Utility	9/1986	10/2010	8	6	$20	hr
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? Numerous duties, including assisting in installation and repair of electric power equipment, underground cable and related activities.

(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	6-8	Stoop *(Bend down & forward at waist.)*	3	Handle large objects	6-8
Stand	6-8	Kneel *(Bend legs to rest on knees.)*	2-3	Write, type, or handle small objects	6-8
Sit	0-1	Crouch *(Bend legs & back down & forward.)*	2-3	Reach	6-8
Climb	3	Crawl *(Move on hands & knees.)*	1-2		

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.)* Heavy machine parts, electrical cable, worked with heavy equipment like transformers, rigged scaffolding & hoists. Carried heavy objects 50-1000 ft most of day.

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 (Go to Section 8 - Medical Treatment.)

Name of Medicine	If prescribed, give name of doctor	Reason for medicine
Aldactone	Dr. Simmons	Remove excess fluid in abdomen
Xanax	Dr. Hill	nervousness
Ibuprofen	Dr. Bates	back pain

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
Midwest Orthopedics	David Bates, M.D.

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

Phone Number	Patient ID# (if known)
312-555-1234	none

Mailing Address: 2325 Front Street

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

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: May 2009	A. none	A. Date in _____ Date out _____
Last Visit: August 2010	B.	B. Date in _____ Date out _____
Next scheduled appointment (if any): June 12, 2011	C.	C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

Low back pain caused by arthritis and disk disease. Arthritis shoulder

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

Physical therapy, light exercise, training proper posture

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 Section11 - 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) Back, shoulder	2009
☐ 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.D. Name of Facility or Office	Name of health care professional who treated you
The Gastroenterology Clinic	John Simmons, M.D.

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

Phone Number	Patient ID# (if known)
312-555-9999	512488

Mailing Address: 17 Outer Loop Drive

City	State/Province	ZIP/Postal Code	Country (If not USA)
Chicago	IL	60686	

Dates of Treatment

1. Office, Clinic or Outpatient visits

First Visit: January 2003

Last Visit: December 2011

Next scheduled appointment (if any): May 2012

2. Emergency Room visits
List the most recent date first

A. none

B.

C.

3. Overnight hospital stays
List the most recent date first

A. Date in 11-2010 Date out 12-2010

B. Date in _____ Date out _____

C. Date in _____ Date out _____

What medical conditions were treated or evaluated?

Liver problem--cirrhosis

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

Surgical shunt to decrease fluid pressure in liver; abdominal fluid drained.

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)	2010	☐ EEG (brain wave test)	
☐ Treadmill (exercise test)		☐ HIV Test	
☐ Cardiac Catheterization		☐ Blood Test (not HIV)	
☒ Biopsy (list body part) Liver	2010	☐ X-Ray (list body part)	
☐ Hearing Test		☒ MRI/CT Scan (list body part) Abdomen	2010
☐ 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
Mental Health Asssociates, Inc.	Henry Hill, M.D.

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

Phone Number	Patient ID# (if known)
312-555-6789	

Mailing Address: 4800 State Building, STE 43

City	State/Province	ZIP/Postal Code	Country (If not USA)
Chicago	IL	60666	

Dates of Treatment

1. Office, Clinic or Outpatient visits	2. Emergency Room visits	3. Overnight hospital stays
First Visit: June 2010	List the most recent date first	List the most recent date first
Last Visit: December 2011	A.	A. Date in ____ Date out ____
Next scheduled appointment (if any): January 2012	B.	B. Date in ____ Date out ____
	C.	C. Date in ____ Date out ____

What medical conditions were treated or evaluated?

Nervousness

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

Talk about how to reduce stress; drugs.

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) mental tests	2010
☐ 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)	
☐ 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.

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 an 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.

Although Dr. Bates originally gave me pain medicine for my back and shoulder it had to be stopped, because it worsened my liver problem. So I have little relief of my back and shoulder pain. I can't bend over because of fluid in my abdomen and back pain. Lifting over 10 lbs. hurts my back and shoulder, and I can't reach overhead with my right arm any more. I feel weak all the time, and cannot do much even around the house: mostly, I sit in a chair and read or watch TV. I try to help with some of the housework, but get tired in a few minutes. My wife now takes care of the car and all of the shopping. Sometimes, my daughter comes over and helps.

All of our savings are about gone. I lost my health insurance when I could no longer work, so my wife lost hers too. I can't afford to get treatment for my cataracts, and my vision is getting worse.

My psychiatrist, Dr. Hill, says that my nervousness will improve if my financial situation gets better. I'd like to learn some other type of work, if I can get help for my medical problems. But I just can't do the heavy work I did before.

Date Report Completed	▶ 10 / 14 / 11 (month, day, year)