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**CLIENT STATUS QUESTIONNAIRE - SOCIAL SECURITY DISABILITY**

*Please complete, sign and Fax, mail or hand-deliver this form to James. H. Sandman, P. C*

CLAIMANTS NAME: \_\_\_\_\_

1	What is your present address?
2	What is your present telephone number?
3	When did you last work?
4	a. Have you attempted to return to work since your disability began even for a trial period?  b. If so, when did you return to work, with whom, your salary or wages, your hours, and your job description
5	When did you last have any contact with the Social Security Administration and what did the contact, whether oral or in writing, concern
6	Are you receiving any disability benefits at this time?
7	How much per week?
8	Which doctors are you still treating with?
9	Last visit?
10	Next visit?
11	Any other comments?

Signature: \_\_\_\_\_

Date: \_\_\_\_\_