

**General Client Information**  
**Law Offices of Daniel A. Parmele, P.C. – Internet**

**OFFICE USE ONLY**

Intake Date: \_\_\_\_\_ SS# \_\_\_\_\_ / \_\_\_\_\_ / \_\_\_\_\_ Status/Date: \_\_\_\_\_  
Intake-Staff: \_\_\_\_\_ Intake-Attorney: \_\_\_\_\_ In person or Chat Date: \_\_\_\_\_

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_ Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Social Security Number: \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

Client Name: \_\_\_\_\_  
*(Minor's) First Middle Last*

Other Names Used: \_\_\_\_\_

Address: \_\_\_\_\_  
*City State Zip Code*

Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_ Cell Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

Place of Birth: \_\_\_\_\_ Name of Mother: \_\_\_\_\_  
*City State*

Mother's Maiden Name: \_\_\_\_\_ Name of Father: \_\_\_\_\_

Email address: \_\_\_\_\_ Household Income: \_\_\_\_\_

Please list three *different* contact persons to assist in contacting you on short notice or in an emergency situation:

1. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ Relationship to: \_\_\_\_\_
2. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ Relationship to: \_\_\_\_\_
3. Name: \_\_\_\_\_ Phone: (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_  
Address: \_\_\_\_\_ Relationship to: \_\_\_\_\_

Does the client have any children less than 18 years of age? \_\_\_\_\_ If so, please specify name(s) and age(s)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Has the claimant received any benefits in regards to: Income assistance, grants, state aid, etc: \_\_\_\_\_  
If so, please specify amounts and dates: \_\_\_\_\_

Has the claimant had any person(s) helping them with any Social Security claim (ex. Attorney, Legal Aid, Caseworker or non-representation)?  Yes  No

If so, please list name, dates, addresses and phone numbers: \_\_\_\_\_

**HOW WERE YOU REFERRED TO OUR OFFICE?**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Television Station? _____         | <input type="checkbox"/> Former Client Who? _____     | <input type="checkbox"/> Friend / Relative Who? _____    |
| <input type="checkbox"/> Phone Book What phone book? _____ | <input type="checkbox"/> Cover of Yellow Pages? _____ | <input type="checkbox"/> Another Attorney Who? _____     |
| <input type="checkbox"/> Internet Where? _____             | <input type="checkbox"/> Search Words? _____          | <input type="checkbox"/> Doctor / Case worker Who? _____ |
| <input type="checkbox"/> Government Agency Who? _____      | <input type="checkbox"/> Other Who? _____             |  |

**Education, Social Security, and Insurance Information**  
**Law Offices of Daniel A. Parmele, P.C. – Internet**

I. Current Grade: \_\_\_\_\_ Teacher's Name: \_\_\_\_\_

IEP/Spec Ed: \_\_\_\_\_ IQ Testing: \_\_\_\_\_

Previous Schools attended: \_\_\_\_\_

Please describe any difficulties in school: \_\_\_\_\_

\_\_\_\_\_

II. Current status of Social Security Disability Claim: \_\_\_\_\_

III. Have you filed any prior application for Social Security Disability? \_\_\_\_\_

If so, please specify date and location: \_\_\_\_\_

IV. Date Disability Began: \_\_\_\_\_

V. Do you have health insurance?  Yes  No Status \_\_\_\_\_

Do you have Medicaid?  Yes  No \_\_\_\_\_

How do you now or in the future plan to pay for medical treatment or medication if you do not have any type of insurance: \_\_\_\_\_

\_\_\_\_\_

VI. Please describe any difficulties experienced in the child's school due to their physical or mental condition.

\_\_\_\_\_

\_\_\_\_\_

Has the child ever been held back in school? Please explain: \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Impairment Information**  
**Law Offices of Daniel A. Parmele, P.C. – Internet**

VII. Please list all Physical/Mental limitations and conditions including all diagnoses, treatments and surgeries:

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VIII. Please identify all impairments or restrictions due to your child's condition.

- Sitting    Standing    Walking    Crouching    Stooping    Bending    Kneeling  
 Lifting    Reaching    Grasping    Headaches    Reading    Writing    Concentration  
 Social Interaction    Depression    Memory    Other: \_\_\_\_\_

IX. Please list all sources of medical treatment during the past two years or since your child's disability began:  
*(Doctors, Hospitals, Psychologists, Physical Therapy, etc.)*

Name/Facility	City/Phone #	Start Date/End Date	Type of provider	Primary
_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>
_____	_____	_____	_____	<input type="checkbox"/>

X. Please list all prescription and over the counter medications your child takes: \_\_\_\_\_

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XI. Side effects from medications:  Drowsiness    Shakiness    Tired    Nausea    Blurred Vision  
 Other, please specify: \_\_\_\_\_

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**CLAIMANT'S SCHOOL BACKGROUND**

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**Start with the most recent (current) school**

**Dates Attended (Approximate) From:** \_\_\_\_\_ **To:** \_\_\_\_\_

**Name of School and Location:** \_\_\_\_\_

**Special Education, IEPs or Disciplinary issues** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Dates Attended (Approximate) From:** \_\_\_\_\_ **To:** \_\_\_\_\_

**Name of School and Location:** \_\_\_\_\_

**Special Education, IEPs or Disciplinary issues** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Dates Attended (Approximate) From:** \_\_\_\_\_ **To:** \_\_\_\_\_

**Name of School and Location:** \_\_\_\_\_

**Special Education, IEPs or Disciplinary issues** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**Dates Attended (Approximate) From:** \_\_\_\_\_ **To:** \_\_\_\_\_

**Name of School and Location:** \_\_\_\_\_

**Special Education, IEPs or Disciplinary issues** \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**AUTHORIZATION TO RELEASE INFORMATION TO  
YOUR CONTACTS**

As a law office we are ethically bound to keep your information from being released to any outside person or agencies without your permission. Please fill in below who you authorize us to speak with in regards to any information we have on file. Should we be contacted by anyone outside of this list we will inform them that we will need written permission from you in order to be able to share any information.

_____	_____
Person or agency	relationship to minor child
_____	_____
Person or agency	relationship to minor child
_____	_____
Person or agency	relationship to minor child
_____	_____
Person or agency	relationship to minor child
_____	_____
Person or agency	relationship to minor child

\_\_\_\_\_  
Parents Signature

\_\_\_\_\_  
Date