

C. Do you have any new illnesses, injuries, or conditions **since you last completed a disability report?** Yes No

If "Yes," please describe in detail:

Approximate date the changes occurred:

Month	Day	Year
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If you need more space, use Section 10 - REMARKS.

SECTION 3 - INFORMATION ABOUT YOUR MEDICAL RECORDS

A. **Since you last completed a disability report**, have you seen or will you see a **doctor/hospital/clinic** or anyone else for the illnesses, injuries, or conditions that limit your ability to work? YES NO

B. **Since you last completed a disability report**, have you seen or will you see a **doctor/hospital/clinic** or anyone else for emotional or mental problems that limit your ability to work? YES NO

C. List **other names** you have used on your medical records.

If you answered "NO" to both A and B, go to Section 4 - MEDICATIONS.

Tell us who may have medical records or other information about your illnesses, injuries, or conditions **since you last completed a disability report.**

D. List each **DOCTOR/HMO/THERAPIST/OTHER**. Include your **next appointment**.

1. NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST VISIT
PHONE () -	PATIENT ID # (If known)		NEXT APPOINTMENT
REASONS FOR VISITS			

WHAT TREATMENT DID YOU RECEIVE?			

2. NAME			DATES	
STREET ADDRESS			FIRST VISIT	
CITY	STATE	ZIP	LAST VISIT	
PHONE () -	PATIENT ID # (If known)		NEXT APPOINTMENT	
<small>Area Code</small>		<small>Phone Number</small>		
REASONS FOR VISITS				
WHAT TREATMENT DID YOU RECEIVE?				

If you need more space, use Section 10 - REMARKS.

E. List each HOSPITAL/CLINIC. Include your next appointment.

HOSPITAL/CLINIC			TYPE OF VISIT	DATES	
NAME			<input type="checkbox"/> INPATIENT STAYS <small>(Stayed at least overnight)</small>	DATE IN	DATE OUT
STREET ADDRESS			<input type="checkbox"/> OUTPATIENT VISITS <small>(Sent home same day)</small>	DATE FIRST VISIT	DATE LAST VISIT
CITY	STATE	ZIP	<input type="checkbox"/> EMERGENCY ROOM VISITS	DATES OF VISITS	
PHONE () -					
<small>Area Code</small>		<small>Phone Number</small>			

Next **appointment** _____ Your hospital/clinic **number** _____

Reasons for visits _____

What **treatment** did you receive? _____

What **doctors** do you see at this hospital/clinic on a regular basis? _____

If you need more space, use Section 10 - REMARKS.

F. Since you last completed a disability report, does anyone else have medical records or information about your illnesses, injuries, or conditions (for example, Workers' Compensation, insurance companies, prisons, attorneys, or welfare agency), or are you scheduled to see anyone else? YES NO

If "YES," complete information below:

NAME			DATES
STREET ADDRESS			FIRST VISIT
CITY	STATE	ZIP	LAST VISIT
PHONE () - Area Code Phone Number			NEXT APPOINTMENT
CLAIM NUMBER (if any)			
REASONS FOR VISITS			

If you need more space, use Section 10 - REMARKS.

SECTION 4 - MEDICATIONS

Are you currently taking any **medications** for your illnesses, injuries or conditions?

YES NO

If "YES," please tell us the following: (*Look at your medicine containers, if necessary.*)

NAME OF MEDICINE	IF PRESCRIBED, GIVE NAME OF DOCTOR	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE

If you need more space, use Section 10 - REMARKS.

SECTION 5 - TESTS

Since you last completed a disability report, have you had any **medical tests** for illnesses, injuries, or conditions or do you have any such tests scheduled? YES NO
 If "YES," please tell us the following: *(Give approximate dates, if necessary.)*

KIND OF TEST	WHEN WAS/WILL TEST BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHETERIZATION			
BIOPSY -- Name of body part _____			
HEARING TEST			
SPEECH/LANGUAGE TEST			
VISION TEST			
IQ TESTING			
EEG (BRAIN WAVE TEST)			
HIV TEST			
BLOOD TEST (NOT HIV)			
BREATHING TEST			
X-RAY -- Name of body part _____			
MRI/CT SCAN -- Name of body part _____			

If you need more space, use Section 10 - REMARKS.

SECTION 6 - UPDATED WORK INFORMATION

Have you worked **since you last completed a disability report**? YES NO

If "YES," you will be asked to give details on a separate form.

SECTION 7 - INFORMATION ABOUT YOUR ACTIVITIES

A. How do your illnesses, injuries, or conditions affect your ability to care for your personal needs?

B. What changes have occurred in your daily activities since you last completed a disability report?

If none, show "NONE."

If you need more space, use Section 10 - REMARKS.

SECTION 8 - EDUCATION/TRAINING INFORMATION

Have you completed any type of **special job training, trade or vocational school since you last completed a disability report?** YES NO

If "YES," describe what type: _____

Approximate date completed: _____

SECTION 9 - VOCATIONAL REHABILITATION, EMPLOYMENT, OTHER SUPPORT SERVICES INFORMATION, OR INDIVIDUALIZED EDUCATION PROGRAM

Since you last completed a disability report, 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;
- an individualized education program through an educational institution (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 NO

If "YES," complete the following information:

NAME OF ORGANIZATION OR SCHOOL _____

NAME OF COUNSELOR OR INSTRUCTOR _____

ADDRESS _____

(Number, Street, Apt. No.(if any), P.O. Box, or Rural Route)

City State ZIP

DAYTIME PHONE NUMBER () - _____
Area Code Number

DATES SEEN _____ TO _____

TYPE OF SERVICES, TESTS, OR EVALUATIONS PERFORMED _____
(IQ, vision, physicals, hearing, workshops, classes, etc.)



Bailey & Galyen

ATTORNEYS AT LAW

PRIVACY POLICY REGARDING SOCIAL SECURITY NUMBERS

Social Security information will only be used in the event you hire the firm to represent you in your legal matter, and then only when necessary in limited use during the course of your case.

- **Social Security numbers are collected by the law firm from the client and all clients provide such information to the firm in writing.**
- **Social Security numbers are most often used to positively identify parties. Some uses may include initial service, in court orders, in orders to withhold wages for child support, in required reports filed with the State of Texas, or to obtain retirement information used to divide retirement benefits. Most courts require Social Security numbers of all parties.**
- **All information received from a client is confidential. Numbers are not released from the firm unless authorized by the client or required in the course of representation as previously stated herein.**
- **The employees of Bailey & Galyen have access to this personal information.**
- **Every step is taken to protect your privacy. This information is kept secure within the offices of the firm in file folders and file drawers until such time that the file information is retired and the file removed to storage in a locked, off-site storage facility. Files will eventually be shredded after the time designated by the State Bar requirement for maintaining the records has expired. Social Security numbers are also kept in firm software programs that are protected by password in our system which is further protected by extensive firewalls.**

I acknowledge that I have read the above privacy information provided by Bailey & Galyen regarding use of my Social Security number.

Signature

Date