

**DISABILITY REPORT
ADULT**

For SSA Use Only
Do not write in this box.

Related SSN _____
Number Holder _____

SECTION 1 — INFORMATION ABOUT THE DISABLED PERSON

A. NAME (First, Middle Initial, Last)

Christopher A. Roller

B. SOCIAL SECURITY NUMBER

471-96-2180

C. DAYTIME TELEPHONE NUMBER (If you have no number where you can be reached, give us a daytime number where we can leave a message for you.)

507 637-8699 Your Number Message Number None
Area Code Number

D. Give the name of a friend or relative that we can contact (other than your doctors) who knows about your illnesses, injuries or conditions and can help you with your claim.

NAME Cathy Roller RELATIONSHIP Mother

ADDRESS 34267 120th St.
(Number, Street, Apt. No. (if any), P.O. Box, or Rural Route)
Redwood Falls MN 56283 DAYTIME PHONE 507 637- 644-5555
City State ZIP Area Code Phone Number

E. What is your height without shoes?

5 11
feet inches

F. What is your weight without shoes?

200
pounds

G. Do you have a medical assistance card? (For example, Medicaid or Medi-Cal) YES NO

If "YES," show the number here: _____

I. Can you speak English? YES NO If "NO," what languages can you speak? _____

If you cannot speak English, is there someone we may contact who speaks English and will give you messages? (If this is the same person as in "D" above, show "SAME" here.)

NAME _____ RELATIONSHIP _____

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

DAYTIME PHONE _____
City State ZIP Area Code Phone Number

I. Can you read English? YES NO **J. Can you write more than your name in English?** YES NO

Exhibit
A

YOUR ILLNESSES, INJURIES OR CONDITIONS AND HOW THEY AFFECT YOU

A. What are the illnesses, injuries or conditions that limit your ability to work? Bipolar

How do your illnesses, injuries or conditions limit your ability to work? Nobody will hire me. Can't find a job.

C. Do your illnesses, injuries or conditions cause you pain? YES NO

D. When did your illnesses, injuries or conditions first bother you?

Month	Day	Year
01	10	1999

E. When did you become unable to work because of your illnesses, injuries or conditions?

Month	Day	Year
02	18	2002

F. Have you ever worked? YES NO (If "NO," go to Section 4.)

G. Did you work at any time after the date your illnesses, injuries or conditions first bothered you? YES NO

H. If "YES," did your illnesses, injuries or conditions cause you to: (Check all that apply.)

- work fewer hours? (Explain below.)
- change your job duties? (Explain below.)
- make any job-related changes such as your attendance, help needed, or employers? (Explain below.)

None

I. Are you working now? YES NO

If "NO," when did you stop working?

Month	Day	Year

Why did you stop working? Company fired me.

SECTION 3 - INFORMATION ABOUT YOUR WORK

A. List all the jobs that you have had in the last 15 years that you worked.

JOB TITLE <i>(Example, Cook)</i>	TYPE OF BUSINESS <i>(Example, Restaurant)</i>	DATES WORKED <i>(month & year)</i>		HOURS PER DAY	DAYS PER WEEK	RATE OF PAY <i>(Per hour, day week, month or year)</i>
		FROM	TO			
Programmer	Software	6/7/99	7/02	8	5	\$78,000 1 yr.
Programmer	Software	2/97	1/99	8	5	\$ 45 1 hr
Programmer	"	5/95	2/97	8	5	\$ 36,000 1 yr.
"	"	1/92	6/94	8	1	\$ 6 1 hr.
Nuclear Electrical Eng	US Navy	10/85	10/91	8	5	\$36,000 1 yr.
						\$ 1
						\$ 1

B. Describe the job above that you did the longest. (What did you do all day in this job?)

→ Maintain & operate a nuclear power plant.

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

Did you supervise other people?

YES NO

If "YES," was this your main duty?

YES NO

D. In this job, how many total hours each day did you:

Walk? 25

Kneel? *(Bend legs to rest on knees.)* 1

Stand? 4

Crouch? *(Bend legs and back down & forward.)* 1

Sit? 3

Crawl? *(Move on hands & knees.)* 1

Climb? 1

Handle, grab or grasp big objects? 5

Stoop? *(Bend down and forward at waist.)* 2

Write, type or handle small objects? 1

E. Lifting and Carrying *(Explain what you lifted, how far you carried it, and how often you did this.)*

small electrical testing equipment, once a week.

F. Check heaviest weight lifted:

Less than 10 lbs. 10 lbs. 20 lbs. 50 lbs. 100 lbs. or more Other _____

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 _____

SECTION 4 - INFORMATION ABOUT YOUR MEDICAL RECORDS

- A. Have you been seen by a doctor/hospital/clinic or anyone else for the illnesses, injuries or conditions that limit your ability to work? YES NO
- B. Have you been seen by a doctor/hospital/clinic or anyone else for emotional or mental problems that limit your ability to work? YES NO

If you answered "NO" to both of these questions, go to Section 5.

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

Tell us who may have medical records or other information about your illnesses, injuries or conditions.

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

1. NAME <i>Dr. Mishra, (V.)</i>			DATES		
STREET ADDRESS <i>Physiatric Services New Ulm Med. Ctr. 3rd floor</i>			FIRST VISIT <i>11/2/02</i>		
CITY <i>New Ulm</i>		STATE <i>MN</i>	ZIP <i>56073</i>		LAST SEEN <i>5/6/03</i>
PHONE <i>800</i> <small>Area Code</small>		PHONE NUMBER <i>795-1211 x168</i>		CHART/HMO #	NEXT APPOINTMENT <i>TBD</i>
REASONS FOR VISITS <i>Zyprexa refill.</i>					
TREATMENT WAS RECEIVED? <i>Yes.</i>					
NAME			DATES		
STREET ADDRESS			FIRST VISIT		
CITY		STATE	ZIP		LAST SEEN
PHONE <small>Area Code</small>		PHONE NUMBER <small>Phone Number</small>		CHART/HMO #	NEXT APPOINTMENT
REASONS FOR VISITS					
WHAT TREATMENT WAS RECEIVED?					

DOCTOR/HMO/THERAPIST

3.

NAME <u>Dr. V. Mishra</u>			DATES	
STREET ADDRESS <u>Psychiatric Services New Ulm Med. Ctr Floor 3</u>			FIRST VISIT <u>11/2/02</u>	
CITY <u>New Ulm</u>	STATE <u>MN</u>	ZIP <u>56073</u>	LAST SEEN <u>5/6/03</u>	
PHONE <u>800 795-1211 x168</u> <small>Area Code Phone Number</small>		CHART/HMO #	NEXT APPOINTMENT <u>TBD</u>	
REASONS FOR VISITS <u>Bipolar</u>				
WHAT TREATMENT WAS RECEIVED? <u>Zyprexa</u>				

If you need more space, use Remarks, Section 9

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

1.

HOSPITAL/CLINIC	TYPE OF VISIT	DATES	
		DATE IN	DATE OUT
NAME <u>New Ulm Medical Center</u>	<input checked="" type="checkbox"/> INPATIENT STAYS (Stayed at least overnight)	<u>11/2/02</u>	<u>11/8/02</u>
STREET ADDRESS <u>1217 8th North street P.O. Box 567</u>	<input type="checkbox"/> OUTPATIENT VISITS (Sent home same day)	DATE FIRST VISIT	DATE LAST VISIT
<u>New Ulm MN 56073</u> CITY STATE ZIP	<input type="checkbox"/> EMERGENCY ROOM VISITS	DATES OF VISITS	
PHONE <u>800 795-1211</u> <small>Area Code Phone Number</small>			

Next appointment 5/6/03 Your hospital/clinic number 768 754Reasons for visits I am GodWhat treatment did you receive? ZyprexaWhat doctors do you see at this hospital/clinic on a regular basis? Dr. V. Mishra

HOSPITAL/CLINIC

2.

HOSPITAL/CLINIC		TYPE OF VISIT		DATES	
NAME <u>New Ulm Medical Center</u>		<input checked="" type="checkbox"/> INPATIENT STAYS (Stayed at least overnight)		DATE IN <u>6/19/99</u>	DATE OUT <u>6/21/99</u>
STREET ADDRESS <u>1217 8th North St.</u>		<input type="checkbox"/> OUTPATIENT VISITS (Sent home same day)		DATE FIRST VISIT	DATE LAST VISIT
<u>P.O. Box 567</u>		<input type="checkbox"/> EMERGENCY ROOM VISITS		DATES OF VISITS	
<u>New Ulm MN 56073</u>					
STATE	CITY				
PHONE <u>800 795-1211</u>					
<small>Area Code</small>	<small>Phone Number</small>				

Next appointment _____ Your hospital/clinic number _____

Reasons for visits

Think I have multiple wives

What treatment did you receive?

Zyprexa

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

If you need more space, use Remarks, Section 9

F. Does anyone else have medical records or information about your illnesses, injuries, or conditions (Workers' Compensation, insurance companies, prisons, attorneys, welfare), or are you scheduled to see anyone else?

YES

(If "YES," complete the information below.)

NO

NAME			DATES	
STREET ADDRESS			FIRST VISIT	
CITY	STATE	ZIP	LAST SEEN	
PHONE <small>Area Code</small> _____ <small>Phone Number</small> _____			NEXT APPOINTMENT	
CLAIM NUMBER (If any) _____				
REASONS FOR VISITS? _____				

If you need more space, use Remarks, Section 9

SECTION 5 - MEDICATIONS

Do you currently take any **medications** for your illnesses, injuries or conditions?
 If "YES," please tell us the following: (Look at your medicine bottles, if necessary.)

YES NO

NAME OF MEDICINE	PRESCRIBED BY (Name of Doctor)	REASON FOR MEDICINE	SIDE EFFECTS YOU HAVE
Zyprexa	V. Mishra	Bipolar	sleepy/loss of creativity

If you need more space, use Remarks, Section 9

SECTION 6 - TESTS

Have you had, or will you have, any **medical tests** for your illnesses, injuries or conditions?

YES NO If "YES," please tell us the following: (Give approximate dates, if necessary.)

KIND OF TEST	WHEN DONE, OR WHEN WILL IT BE DONE? (Month, day, year)	WHERE DONE? (Name of Facility)	WHO SENT YOU FOR THIS TEST?
EKG (HEART TEST)			
TREADMILL (EXERCISE TEST)			
CARDIAC CATHERIZATION			
BIOPSY Name of body part _____			
HEARING 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 have had any other tests, list them in Remarks, Section 9.

SECTION 7 - EDUCATION/TRAINING INFORMATION

A. Circle the highest grade of school completed.

0 1 2 3 4 5 6 7 8 9 10 11 12 GED College: 1 2 3 4 or more

Approximate date completed: _____

B. Did you attend special education classes? YES NO If "YES,"

NAME OF SCHOOL _____

ADDRESS _____

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

City State ZIP

DATES ATTENDED _____ TO _____

TYPE OF PROGRAM _____

C. Have you completed any type of special job training, trade or vocational school? YES NO

If "YES," what type? US Navy Nuclear Power Training

Approximate date completed: 10/87

SECTION 8 - VOCATIONAL REHABILITATION INFORMATION

A. Have you received services from Vocational Rehabilitation or any other organization to help you get back to work? YES NO If "YES,"

NAME OF _____

NAME OF COUSELOR _____

ADDRESS _____

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

City State ZIP

DAYTIME PHONE _____
Area Code Number

DATES SEEN _____ TO _____

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

B. Would you like to receive rehabilitation services that could help you get back to work? YES NO

ANYONE MAKING A FALSE STATEMENT OR REPRESENTATION OF A MATERIAL FACT FOR USE IN DETERMINING A RIGHT TO PAYMENT UNDER THE SOCIAL SECURITY ACT COMMITS A CRIME PUNISHABLE UNDER FEDERAL LAW.

Signature of claimant or person filing on claimant's behalf (Parent, guardian)

Date (Month, day, year)

[Handwritten Signature]

7/24/2003

Witnesses are required ONLY if this statement has been signed by mark (X) above. If signed by mark (X), two witnesses to the signing who know the person making the statement must sign below giving their full addresses.

1. Signature of Witness

1. Signature of Witness

Address (number and street, city, state, and ZIP code)

Address (number and street, city, state, and ZIP code)