MEDICAL SOURCE STATEMENT
About What the Claimant Can Still Do Despite Impairment(s)

Name _____ Social Security No. _____

INSTRUCTIONS: Please complete the following assessment based on your clinical evaluation and test findings. You are not required to perform any special test of functional capacity to render your opinions on this form.

1. Nature, frequency and length of contact: _____

2. Diagnoses: _____
_____

3. Identify all of your patient's symptoms, including pain , dizziness, fatigue, etc.
_____
_____

4. If your patient has pain, characterize the nature, location, frequency, precipitating factors and severity of your patient's pain.
_____
_____

5. Identify any positive objective signs:

___ Reduced range of motion:
Joints affected: _____
_____

____Joint warmth
____Joint deformity
____Joint instability
____Reduced grip strength

____ Sensory changes
____Reflex changes
____Impaired sleep
____Weight change
____Impaired appetite
____Abnormal posture
____Tenderness
____Crepitus

____ Trigger points
____ Redness
____ Swelling
____ Muscle spasm
____ Muscle weakness
____Muscle atrophy
____Abnormal gait
____Positive straight leg raising test

Other clinical findings: _____

_____

6. Is your patient a malingerer? ____Yes ____No

7. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? ____Yes ____No

8. Identify any psychological conditions affecting pain:

____Depression ____Anxiety
____Somatoform disorder ____Personality disorder
____Psychological factors affecting physical condition

Other: _____

9. Are your patient's impairments (physical impairments plus any emotional impairments) reasonably consistent with the symptoms and functional limitations described in this evaluation? ____Yes ____No

If no, please explain: _____

_____

10. How often is your patient's experience of pain severe enough to interfere with attention and concentration?

___ Never ___ Seldom ___ Often ___ Frequently ___ Constantly

11. To what degree is your patient limited in the ability to deal with work stress?

___No limitation ___ Slight Limitation ___Moderate Limitation
___Marked Limitation ___ Severe Limitation

12. Identify the side effects of any medication which may have implications for working, e.g., dizziness, drowsiness, stomach upset, etc. _____

_____

13. Have your patient's impairments lasted or can they be expected to last at least twelve months? ____Yes ____No

14. Please mark the activities the patient CAN perform <u>on a regular and continuing basis</u>. 'A regular and continuing basis" means 8 hours a day for 5 days a week, or an equivalent work schedule.

SITTING in a working position at a desk or table without reclining.

A) MAXIMUM CONTINUOUSLY sitting before alternating postures standing or walking about. (Check one please)
<15 min 15 min 1 hr 2 hrs 3 hrs >3 hrs

B) After sitting for the maximum continuous period, does this patient need to ALTERNATE POSTURES by standing or walking about? (Check 1 please)

___ YES, by walking about.
___ YES, but standing in place is sufficient
___ NO, alternating postures is not medically indicated.

C) If so, HOW LONG does the patient need to stand or walk about before returning to a seated position for another maximum continuous interval? (Circle one please)
<15 min 15 min 30 min 1 hr 2 hrs 3 hrs >3 hrs

D) Is it medically necessary for this patient to elevate the legs while SITTING to minimize pain?

____ Yes, BOTH legs
____ Yes, RIGHT leg only
____ Yes, LEFT leg only
____ No, it is not necessary to elevate either leg while sitting.

E) If elevation of the patient's legs is medically necessary, what DEGREE of elevation is appropriate?
____ Elevation to chest level or higher
____ Elevation to waist level
____ Elevation to only six inches or less

F) TOTAL CUMULATIVE sitting during an 8 hour work day, NOT INCLUDING time spent standing or walking about. (Circle one please)
<1 hr 2 hrs 3 hrs 4 hrs 5 hrs 6 hrs >6 hrs

15. STANDING AND WALKING ABOUT: weightbearing ambulating.

A) maximum continuously STANDING OR WALKING ABOUT before alternating postures sitting or lying down. (Circle one please)
<15 min 15 min 30 min 1 hr 2 hrs 3 hrs >3 hrs

B) After standing or walking about for the maximum continuous period, does this patient need to ALTERNATE POSTURES by sitting lying down or reclining in a supine positions?

____ YES, by lying down or reclining in a supine position.
____ YES, but sitting in a working position at a desk or table is sufficient.
___ NO, alternating postures is not medically indicated.

C) If so, HOW LONG does the patient need to sit or lie down/recline before returning to standing or walking about for another maximum continuous interval? (Circle one please)

<15 min 15 min 30 min 1 hr 2 hrs 3 hrs >3 hrs

D) TOTAL CUMULATIVE standing or walking about during an NOT INCLUDING time spent sitting or lying down/reclining. (Circle one please)

<1 hr 1 hr 2 hrs 3 hrs 4 hrs 5 hrs 6 hrs >6 hrs

16. RESTING lying down or reclining in a supine position in bed or in an easy chair.

A) Does this patient need to REST for some period of time during an 8 hour work day? (Circle one please)

_____ YES, in addition to a morning break, a lunch period, and an afternoon break scheduled at approximately 2 hour intervals, more rest is needed.

_____ YES, but a morning break, a lunch period, and an afternoon break scheduled at approximately 2 hour intervals is sufficient.

_____ NO, rest lying down or in a supine position in bed or in an easy chair is not medically indicated.

B) If so, WHY does the patient need REST for some period of time during an 8 hour work day? (Check one please)

_____ To relieve pain arising from a documented medical impairment
_____ To relieve fatigue arising from a documented medical impairment
_____ Non-Applicable. rest as defined is not medically indicated.

C) If so, what is the TOTAL CUMULATIVE resting/lying down or reclining in a supine position needed during an 8 hours work day?

<1 hr 2 hrs 3 hrs 5 hrs >6 HRS

17. RECAP OF TOTALS SITTING, STANDING/WALKING ABOUT & RESTING as indicated in answers to Nos. 15 and 16 above.

TOTAL CUMULATIVE sitting _____ hrs
TOTAL CUMULATIVE standing/walking about +____ hrs
TOTAL CUMULATIVE resting +____ hrs

18. LIFTING AND CARRYING (Check one at each weight level)

Weight in Pounds	Rarely/None (no sustained/8hrs	Occasionally (<1/3 of 8hrs)	Frequently (1/3-2/3 of 8hrs)	Constantly ((>2/3 of 8hrs)
1-5 lbs.				
6-10 lbs.				
11-20 lbs.				
21-50 lbs.				

19. Balancing when standing/walking on level terrain (check one)

20. STOOPING bending the body downward and forward by bending the spine at the waist (check one)

21. Postures of the Neck:

A) Forward Flexion (i.e. Looking down at a table or desk)

B) Backward Flexion (i.e. Looking upward to ceiling/sky)

C) Rotation Right (i.e. Looking sideways to right)

D) Rotation Left (i.e. Looking sideways to left)

REPETITIVE USE OF HANDS

A) Reaching (i.e. extending the hands and arms in any direction)

	Rarely/None	Occasionally	Frequently	Constantly
RIGHT HAND	_____	_____	_____	_____
LEFT HAND	_____	_____	_____	_____

B) Handling (i.e. seizing, grasping, turning or otherwise working primarily with the whole hand)

RIGHT HAND	_____	_____	_____	_____
LEFT HAND	_____	_____	_____	_____

C) Fingering (i.e. picking, pinching or otherwise working primarily with the fingers)

RIGHT HAND	_____	_____	_____	_____
LEFT HAND	_____	_____	_____	_____

22. ASSISTIVE DEVICES FOR AMBULATING

A) Is a hand held assistive device medically required to aid the patient in walking or standing?

____ YES, to aid in BOTH walking and standing
____ YES, to aid in ONLY walking, not standing
____ NO

B) If so, what TYPE of hand-held assistive device is medically required?

___ CANE
___ WALKER
___ 2 CRUTCHES
___ 1 CRUTCH

C) If so, in what CIRCUMSTANCES is the hand-held assistive device medically required?

___ On ALL surfaces and terrains for all ambulation
___ ONLY on uneven surfaces and terrains or slopes
___ ONLY for prolonged ambulation

23. Are your patient's impairments likely to produce "good days" and "bad days"?

If yes, please estimate, on the average, how often your patient is likely to be absent from work as a result of the impairments or treatment:

___ Never
___ Less than once a month
___ About once a month
___ About twice a month
___ About 3 times a month
___ More than 3 times a month

24. PERIOD OF RESTRICTION:

Has the patient's condition existed and persisted with the restrictions as outlined in this Medical Source Statement at least since _____?

___ Yes
___ No

If not, state the first date the patient's condition existed and persisted with such restrictions:
_____?

CERTIFICATION

By my signature appended hereto, I attest that I personally have answered each of the questions presented in this Medical Source Statement assessment form and I believe the information contained herein to be true and accurate to the best of my knowledge and professional judgment.

Dated _____,

_____
Physician's Signature

_____
Physician's Name Printed

_____
Physician's Address