PHYSICAL MEDICAL SOURCE STATEMENT

Re:_____

SS:_____

The Social Security Administration needs your expert opinion of your patient's functional limitations caused by his/her impairments. You likely will never be asked to do anything else as a result of completing this form.

Please answer the following questions concerning your patient's impairments. Attach all relevant treatment notes, radiologist reports, laboratory and test results that have not been provided previously to the Social Security Administration.

1. **Frequency and length of contact:**_____

2. **Diagnoses:**_____

3. **Prognosis:**_____

4. **List your patient's symptoms, including pain, dizziness, fatigue, etc.:**

   _____

   _____

5. **If your patient has pain, characterize the nature, location, frequency, precipitating factors and severity of your patient's pain:**

   _____

   _____

6. **Identify the clinical findings and objective signs:**

   _____

   _____

7. **Describe the treatment and response including any side effects of medication that may have implications for working, e.g., drowsiness, dizziness, nausea, etc.:**

   _____

   _____

8. **Have your patient's impairments lasted or can they be expected to last at least 12 months?** ___Yes ___No

9. **Is your patient a malingerer:** ___Yes ___No

10. **Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?** ___Yes ___No

11. **Identify any psychological conditions affecting your patient's physical condition:**

___Depression
___Somatoform disorder
___Psychological factors affecting physical condition
___Anxiety
___Personality disorder
___Other: _____

12. 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:_____

13. How often during a typical workday is your patient's experience of pain or other symptoms severe enough to interfere with attention and concentration needed to perform even simple work tasks?

___Never ___Rarely ___Occasionally ___Frequently ___Constantly

For this and other questions on this form, "rarely" means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.

14. To what degree can your patient tolerate work stress?

___Incapable of even low stress jobs
___Moderate stress is okay
___Capable of low stress jobs
___Capable of high stress work

Please explain the reasons for your conclusion:_____

_____

15. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a *competitive work situation*.

a. How many city blocks can your patient walk without rest or severe pain?_____

b. Please circle the hours and/or minutes that your patient can sit at one time, e.g., before needing to get up, etc.

Sit: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

c. Please circle the hours and/or minutes that your patient can stand at one time, e.g., before needing to sit down, walk around, etc.

Stand: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

d. Please indicate how long your patient can sit and stand/walk total in an 8-hour working day (with normal breaks):

Sit		Stand/Walk	
___	less than 2 hours	___	less than 2 hours
___	about 2 hours	___	about 2 hours
___	about 4 hours	___	about 4 hours
___	at least 6 hours	___	at least 6 hours

e. Does your patient need to include periods of walking around during an 8-hour working day? ___Yes ___No

1) If yes, approximately how often must your patient walk?

1 5 10 15 20 30 45 60 90
Minutes

2) How long must your patient walk each time?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Minutes

f. Does your patient need a job that permits shifting positions *at will* from sitting, standing or walking? ___Yes ___No

g. In addition to normal breaks, will your patient need to take unscheduled breaks during an 8-hour working day? ___Yes ___No

If yes, 1) how often do you think this will happen?_____
2) how long (on average) will your patient have to rest before returning to work?_____

h. With prolonged sitting, should your patient's leg(s) be elevated? ___Yes ___No

If yes, 1) how high should the leg(s) be elevated?_____
2) if you patient had a sedentary job, what percentage of time during an 8-hour working day should the leg(s) be elevated?_____

i. While engaging in occasional standing/walking, must your patient use a cane or other assistive device? ___Yes ___No

j. How many pounds can your patient lift and carry in a competitive work situation?

	Never	**Rarely**	**Occasionally**	**Frequently**
Less than 10 lbs.		___	___	___
10 lbs.	___	___	___	___
20 lbs.	___	___	___	___
50 lbs.	___	___	___	___

k. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Look down (sustained flexion of neck)	___	___	___	___
Turn head right or left	___	___	___	___
Look up	___	___	___	___
Hold head in static position	___	___	___	___

l. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Twist	___	___	___	___

Stoop (bend)	___	___	___	___
Crouch/squat	___	___	___	___
Climb ladders	___	___	___	___
Climb stairs	___	___	___	___

m. Does your patient have significant limitations with reaching, handling or fingering? ___Yes ___No

If yes, please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn Twist Objects	**FINGERS: Fine Manipulations**	**ARMS: Reaching (Incl. over head)**
Right:	%	%	%
Left:	%	%	%

n. Are your patient's impairments likely to produce good days and bad days?
___Yes ___No

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

___Never
___About one day per month
___About two days per month
___About three days per month
___About four days per month
___More than four days per month

16. **Please attach an additional page to describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis.**

17. **What is the EARLIEST DATE that the description of symptoms and limitations in this questionnaire applies?**

_____
DATE ABOVE LIMITATIONS BEGAN

_____
Date Completed

X_____
Supervising Doctor Signature

PRINTED NAME: _____

ATTACH BUSINESS CARD HERE

(or letterhead, if faxing)

_____
Provider who completed form, if different

J DISABILITY PLLC
LAW FIRM