MEDICAL SOURCE STATEMENT (Physical)

Patient Name: _____

DOB: _____

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 twelve months?

☐ Yes ☐ No

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

☐ Yes ☐ No

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

☐ Depression
☐ Somatoform disorder
☐ Psychological factors affecting physical condition
☐ Anxiety
☐ Personality disorder
☐ Other: _____

11. 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: _____

12. How much is your patient likely to be ***"off task"***? That is, what percentage of a typical workday would your patient's symptoms likely be severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks?

☐ 0% ☐ 5% ☐ 10% ☐ 15% ☐ 20% ☐ 25% or more

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

☐ Incapable of even "low stress" jobs

☐ Moderate stress is okay ☐ Capable of high stress work

Please explain the reasons for your conclusion: _____

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

Sit: _____ Minutes _____ Hours

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

Stand: _____ Minutes _____ 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
☐	☐	about 2 hours
☐	☐	about 4 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?

_____
Minutes

2) How *long* must your patient walk each time?

_____
Minutes

f. Does your patient need a job that permits shifting positions *at will* from sitting, standing or walking? ☐ Yes ☐ No

g. Will your patient sometimes 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 your 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	**Occasionally (up to 1/3)**	**Frequently (1/3 to 2/3)**	**Continuously (over 2/3)**
Less than 10 lbs.	☐	☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

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

	Never	**Occasionally (up to 1/3)**	**Frequently (1/3 to 2/3)**	**Continuously (over 2/3)**
Look down (sustained flexion of neck)	☐	☐	☐	☐
Turn head right or left	☐	☐	☐	☐
Look up	☐	☐	☐	☐
Hold head in static position	☐	☐	☐	☐

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

	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
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. Overhead)**
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 the 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.

_____ _____

Date ***Signature***

Printed Name & Title: _____

Address: _____

_____