THESE ARE THE FORMS I USE – THIS IS NOT LEGAL ADVICE AND INTENDED TO SUPPLEMENT YOUR PARTICULAR FACTUAL SITUATION ONLY – It is crucial you educate yourself on the Social Security Regulations that define and govern impairments prior to preparing this form for review. ***Absolutely, this form should be modified to address the specific impairment as identified in the SSA Listings of Impairments of Adults.***

Lee Ann Torrans

Residual Functional Capacity
SSA Listed Disorders

Name:	SSN: DOB:
Health Care Provider Name:	
Health Care Provider Relationship to Patient:	
When First Treated Patient:	
How Often Sees Patient:	
Primary Diagnosis:	Date of Onset:
Secondary Diagnosis:	Date of Onset:
Other Impairments:	Date of Onset:

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. To determine this individual's ability to do work-related activities on a regular and continuous basis, please give us your opinions for each activity shown below.

The following terms are defined as:

- REGULAR AND CONTINUOUS BASIS means 8 hours a day, for 5 days a week, or an equivalent work schedule.
- OCCASIONALLY means very little to one-third of the time.
- FREQIENTLY means from one-third to two-thirds of the time.
- CONTINUOUSLY or CONSTANTLY means more than two-thirds of the time.

Age and body habitus of the individual should not be considered in the assessment of limitations. It is important that you relate particular medical or clinical findings to any assessed limitations in capacity: The usefulness of your assessment depends on the extent to which you do this.

Nature, frequency and length of contact:

Diagnoses:

Identify the particular medical or clinical findings (*i.e*., physical exam findings, x-ray findings, laboratory test results, history. and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

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

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

Identify any positive objective signs:

___ Reduced range of motion:

Joints affected: ____

____Joint warmth ____Joint deformity ____Joint instability ____Reduced grip strength

____ Sensory changes ____ Trigger points ____Reflex changes ____ Redness

____Impaired sleep ____ Swelling ____Weight change ____ Muscle spasm

____Impaired appetite ____ Muscle weakness ____Abnormal posture ____Muscle atrophy

____Tenderness ____Abnormal gait ____Crepitus ____Positive straight leg raising test

Other clinical findings:

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

Identify any psychological conditions affecting pain:

____Depression ____Anxiety____Somatoform disorder ____Personality disorder

____Psychological factors affecting physical condition

Other:

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

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

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

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

MEDICATIONS

List Prescribed Medications and identify condition for which medications are prescribed.

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

Is there a reasonable medical probability your patient will experience side effects from the medication(s) listed above?

☐ Yes ☐ No

Other:

To what degree will the side effects of the prescribed medications impair your patient's ability for concentration, persistence and pace in combination with the underlying condition(s)?

☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other ☐ Not Able to Assess

When side effects exist can you estimate the severity?

☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other ☐ Not Able to Assess

Is your patient allowed to operate machinery or motorized vehicles when experiencing side effects from the medication?

☐ Yes ☐ No

Is there a reasonable medical probability that the side effects will reduce your patient's ability to perform work to a minimum standard of productivity? If yes, to what degree:

☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other ☐ Not Able to Assess

Is there a reasonable medical probability that the side effects will reduce your patient's ability to perform detailed work requiring hand/eye coordination? If yes, to what degree:

☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other ☐ Not Able to Assess

Is there a reasonable medical probability that the side effects will reduce your patient’s cognitive acuity and/or ability to focus on activities such as reading, writing, computer use? If yes, to what degree:

☐ Mild ☐ Slight ☐ Moderate ☐ Severe ☐ Other ☐ Not Able to Assess

11. Please mark the activities the patient CAN perform on a regular and continuing basis. ‘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. (Circle one please)

Less than15 min --15 min --- 1 hr --- 2 hrs --- 3 hrs --- less than 3 hrs

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

Less than15 min --15 min --- 1 hr --- 2 hrs --- 3 hrs --- less than 3 hrs

D) Is it medically necessary for this patient to elevate the legs while SITTING to minimize pain? (check one please).

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

12. STANDING AND WALKING ABOUT: weight bearing ambulating.

A) maximum continuously STANDING OR WALKING ABOUT before alternating postures sitting or lying down. (Circle one please)

Less than15 min --15 min --- 1 hr --- 2 hrs --- 3 hrs --- less than 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)

Less than15 min --15 min --- 1 hr --- 2 hrs --- 3 hrs --- less than 3 hrs

D) TOTAL CUMULATIVE standing or walking about during an 8-hour work day NOT INCLUDING time spent sitting or lying down/reclining. (Circle one please)

Less than 1 hr --- 1 hr --- 2 hrs --- 3 hrs --- 4 hrs --- 5 hrs --- 6 hrs --- Less than 6 hrs

13. 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 eight hour work day? (Circle one please)

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

_____ YES, but a morning break, a lunch period, and an afternoon break scheduled at approximately two 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 eight hour work day?

Less than 1 hr --- 1 hr --- 2 hrs --- 3 hrs --- 4 hrs --- 5 hrs --- 6 hrs --- Less than 6 hrs

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

Weight in Pounds: 1-5 lbs.

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

Weight in Pounds: 6-10 lbs.

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

Weight in Pounds: 11-20 lbs.

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

Weight in Pounds: 21-50 lbs.

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

15. BALANCING when standing/walking on level terrain (check one)

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

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

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

17. POSTURES of Neck:

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

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

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

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

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

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

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

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

REPETITIVE USE OF HANDS

Which is the individual's physical dominant hand (circle one): Right or Left

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

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

RIGHT HAND

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

LEFT HAND

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

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

RIGHT HAND

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

LEFT HAND

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

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

RIGHT HAND

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

LEFT HAND

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly ☐ No ☐ Not Able to Assess

Please check the frequency with which the patient can perform the following activities:

Percentage of Time	Never	Rarely – 0-30%	Frequently- 30-70%	Consistently – 70-100%
Reach Up Above Shoulders				
Reach Down to Waist Level				
Reach Down Towards Floor				
Carefully Handle Objects				
Handle with Fingers				

Assistive Devices Required 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?

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: (Circle One)

___ Never ___ About twice a month ___ Less than once a month _

About 3 times a month___ About once a month ___ More than 3 times a month

If the patient has any complaints of pain, please address the following questions:

What is the nature of the pain?

Is there an objective reason for the pain supported by medical evidence?

How frequent is the pain?

What is the level of pain on a scale of one to ten?

How would you rate the patients' creditability with regards to claims of pain?

Hearing or Vision Impairments

1. If a hearing impairment is present,

A. Does the individual retain the ability to hear and understand Simple oral instructions and to communicate simple information? Yes ___ No ___

B. Can the individual use a telephone to communicate? Yes ___ No ___

2. If a visual impairment is present:

A. Is the individual able to avoid ordinary hazards in the workplace, such as boxes on the floor, doors ajar, or approaching people or vehicles? Yes ___ No ___

B. Is the individual able to read very small print? Yes ___ No ___

C. Is the individual able to read ordinary newspaper or book print? Yes ___ No ___

D. Is the individual able to view a computer screen? Yes ___ No ___

E. Is the individual able to determine differences in shape and color of small objects such as screws, nuts or bolts? Yes ___ No ___

Identify the particular medical or clinical findings (*i.e.,* physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

Individual Activities

Can the individual perform activities like shopping? Yes ___ No ___

Can the individual travel without a companion for assistance? Yes ___ No ___

Can the individual ambulate without using a wheelchair, walker, or 2 canes or 2 crutches? Yes ___ No ___

Can the individual walk a block at a reasonable pace on rough or uneven surfaces? Yes ___ No ___

Can the individual use standard public transportation? Yes ___ No ___

Can the individual climb a few steps at a reasonable pace with the use of a single hand rail? Yes ___ No ___

Can the individual prepare a simple meal and feed himself/herself? Yes ___ No ___

Can the individual care for personal hygiene? Yes ___ No ___

Can the individual sort, handle, use paper and/or files? Yes ___ No ___

Please identify the medical findings that support this assessment and why the findings support the assessment (unless a narrative report is attached).

Environmental Factors and Limitations

Condition	Never	Occasionally (up to *1/3)*	Frequently *(1/3* to *213)*	Continuously (over 2/3)
Unprotected Heights				
Moving Mechanical Parts				
Operating a motor vehicle				
Humidity and wetness				
Dust. odors, fumes and pulmonary irritants				
Extreme cold				
Extreme heat				
Vibrations				
Other: (Identify)				

Condition	Quiet (Library)	Moderate (Office)	Loud (Heavy Traffic)	Very Loud (Jackhammer)
Noise				

Individual's Ability to Travel

Would the patients disability or impairment prevent him or her from travelling alone?

Yes _____ No ______Why?

Individual's Time Period of Restriction(s)

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:

______________________?

How would you expect the claimant's diagnosis/disability to change over time?

____ Disability is Not Likely to Change
____Disability is Temporary: From: _________To: ____________

When would you expect the claimant to return to work, with and/or without any restrictions?

Please

Are there any other factors not addressed in the above questions that you believe may affect the patients' ability to work, or function normally in daily life including at work and at home?

STATE ANY OTHER WORK-RELATED ACTIVITIES, WHICH ARE AFFECTED BY ANY IMPAIRMENTS, AND INDICATE HOW THE ACTNITIES ARE AFFECTED. WHAT ARE THE MEDICAL FINDINGS -THAT SUPPORTS THIS ASSESSMENT?

THE LIMITATIONS ABOVE ARE ASSUMED TO BE YOUR OPINION REGARDING CURRENT LIMITATIONS ONLY. HOWEVER, IF YOU HAVE SUFFICIENT INFORMATION TO FORM AN OPINION WITHIN A REASONABLE DEGREE OF MEDICAL PROBABILITY AS TO PAST LIMITATIONS, ON WHAT DATE WERE THE LIMITATIONS YOU FOUND ABOVE FIRST PRESENT?

HAVE THE LIMITATIONS YOU FOUND ABOVE LASTED OR WILL THEY LAST FOR 12 CONSECUTIVE MONTHS? ___ Yes ___ No

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