SOCIAL SECURITY PHC WORKSHEET (OUTLINE FOR HEARING)

NAME _____ SSN _____ AGE _____ DOB _____

HEIGHT _____ WEIGHT _____ EDUCATION _____ MILITARY _____

Ability to ready & write: Good _____ Fair _____ Poor _____

LDW _____ Job duties _____

WORK HISTORY (Past 15 years)

_____ _____
_____ _____
_____ _____

PHYSICAL PROBLEMS _____
Symptoms _____
Mental condition _____
Lift _____ lbs. Explain _____
Sit _____ Explain _____
Stand _____ Explain _____
Walk _____ Explain _____

Tell the Judge why you cannot work _____
_____
_____

Treating doctor _____ _____
Other doctors _____ _____
_____ _____

Prescriptions _____ _____
_____ _____
_____ _____

V.E. ISSUES : _____

Date of Hearing _____ Place _____
ALJ _____ ALJ Mood _____
On the record decision: Yes_____ No _____ Guess: Win or Lose
Request medical records from: Deadline:
_____ _____
_____ _____

ALJ WILL SCHEDULE C.E.: Yes ☐ No ☐ Type _____

We Need I.M.E. _____
School Records from: _____

SOCIAL SECURITY FILE REVIEW

Q. **What is the biggest problem that keeps you from working?**
A. _____

_____

Q. **Other problems?**
A. _____

_____

Q. **Nerves/anxiety/depression?**
A. _____

_____

Q. **Who is primary doctor? Last seen?**
A. _____

_____

Q. **Other specialists?**
A. _____

_____

Q. **Other appointments?**
A. _____

_____

Q. **Recent diagnostic testings? MRI? CT Scan?**
A. _____

_____

Q. **Recent hospitalizations?**
A. _____

_____

Q. **Anything new or different?**
A. _____

_____

SOCIAL SECURITY INTERROGATORIES
FOR EXAMINING PHYSICIAN'S OPINION

MEDICAL OPINION OF : _____,M.D.

IN THE CASE OF : _____ SSN: _____

1. **Q.** Does your attached medical report contain sufficient information for you to formulate an opinion as to whether the claimant has any medically determinable impairment(s)?

   A. YES ( ) NO ( )
   (Give Rationale)

2. **Q.** Based on your attached medical report, what impairment(s) are demonstrable by medically acceptable clinical and laboratory diagnostic techniques?

   A.

3. **Q.** If the claimant has any medically determinable impairment(s), what mental and emotional limitation, restrictions and manifestations would reasonably be associated with the impairment(s) described?

   A.

4. **Q.** Were the claimant's impairment(s) singly or in combination, of such a nature so as to disable the claimant from engaging in substantial gainful activities?

   A. YES ( ) NO ( ) CANNOT DETERMINE ( )

   Basis for medical opinion:

DATE: _____

SIGNATURE: _____

SOCIAL SECURITY ADMINISTRATION
OFFICE OF HEARINGS AND APPEALS

Form Approved
OMB NO. 0960-0662

MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)

NAME OF INDIVIDUAL

SOCIAL SECURITY NUMBER

To assist us in determining this individual's ability to do work-related activities, please give us your professional opinion of what the individual can still do despite his her impairment(s). The opinion should be based on your findings with respect to medical history, clinical and laboratory findings (or lack thereof), diagnosis, prescribed treatment and response, expected duration and prognosis.

For each activity shown below:
(1) Check the appropriate block;
(2) Respond to the questions about the individual's ability to perform the activity; and
(3) Identify the factors (e.g., the particular medical signs, laboratory findings, or other factors described above) that support your assessment of any limitations.

IT IS VERY IMPORTANT TO DESCRIBE THE FACTORS THAT SUPPORT YOUR ASSESSMENT. WE ARE REQUIRED TO CONSIDER THE EXTENT TO WHICH YOUR ASSESSMENT IS SUPPORTED.

EXERTIONAL LIMITATIONS

1. Are **LIFTING/CARRYING** affected by the impairment? ☐ No ☐ Yes

If "yes," how many pounds can the individual lift and/or carry?
Frequently means occurring one-third to two-thirds of an 8-hour workday (cumulative, not continuous).
Occasionally means occurring from very little up to one-third of an 8-hour workday (cumulative, not continuous).

Occasionally lift and/or carry (including upward pulling)
(maximum) -when less than one-third of the time or less than 10 pounds, explain the amount (time/pounds) in item 5.

- ☐ less than 10 pounds
- ☐ 10 pounds
- ☐ 20 pounds
- ☐ 25 pounds
- ☐ 50 pounds
- ☐ 100 pounds or more

Frequently lift and/or carry (including upward pulling)
(maximum) - when less than two-thirds of the time or less than 10 pounds. explain the amount (time/pounds) in item 5.

- ☐ less than 10 pounds
- ☐ 10 pounds
- ☐ 20 pounds
- ☐ 25 pounds
- ☐ 50 pounds
- ☐ 100 pounds or more

2. Are **STANDING and/or WALKING** affected by the impairment? ☐ No ☐ Yes

If "yes," how many hours total (with normal breaks) can the individual stand andlor walk?

- ☐ less than 2 hours in an 8-hour workday (If less than two hours selected provide explanation of the precise limitation opined below)
- ☐ at least 2 hours in an 8-hour workday
- ☐ about 6 hours in an 8-hour workday
- ☐ medically required hand-held assistive device is necessary for ambulation

3. Is **SITTING** affected by the impairment? ☐ No ☐ Yes

☐ less than 6 hours in an 8-hour workday
☐ about 6 hours in an 8-hour workday
☐ must periodically alternate sitting and standing to relieve pain or dismmfort. (If checked, explain in item 5.)

4. Is **PUSHING and/or PULLING** affected by the impairment? ☐ No ☐ Yes
(including operation of hand and/or foot controls)
If "yes," check appropriate block.
☐ limited in upper extremities (describe nature and degree)
☐ a limited in lower extremities (describe nature and degree)

5. What medical/clinical finding(s) support your conclusion in item 1-4 above?

POSTURAL LIMITATIONS
How often can the individual perform the following **POSTURAL** activities?
Frequently means occurring one-third to two-thirds of an 8-hour workday (cumulative, not continuous).
Occasionally means occurring from very little up to one-third of an 8-hour workday (cumulative, not continuous).

	Frequently	Occasionally	Never
1. Climbing - ramps/stairs/ladder/rope/scaffold	☐	☐	☐
2. Balancing	☐	☐	☐
3. Kneeling	☐	☐	☐
4. Crouching	☐	☐	☐
5. Crawling	☐	☐	☐
6. Stooping	☐	☐	☐

When less than two-thirds of the time for frequently or less than one-third for occasionally, fully describe and explain.

MANIPULATIVE LIMITATIONS
Are the following **MANIPULATIVE** functions affected by the impairment:

	LIMITED	UNLIMITED
1. Reaching all directions (including overhead)	☐	☐
2. Handing (gross manipulation)	☐	☐
3. Fingering (fine manipulation)	☐	☐
4. Feeling (skin receptors)	☐	☐

If there are manipulative limitations described as "limited", please check how often the individual can do the following.

☐ REACHING	☐ OCCASIONALLY	☐ FREQUENTLY	☐ CONSTANTLY
☐ HANDLING	☐ OCCASIONALLY	☐ FREQUENTLY	☐ CONSTANTLY
☐ FINGERING	☐ OCCASIONALLY	☐ FREQUENTLY	☐ CONSTANTLY
☐ FEELING	☐ OCCASIONALLY	☐ FREQUENTLY	☐ CONSTANTLY

5. Describe how the activities checked "limited" are impaired and the basis of additional manipulative limitations. What medical/clinical findings support your conclusions?

VISUAL/COMMUNICATIVE LIMITATIONS
Are the following functions affected by the impairment?

	LIMITED	UNLIMITED
1. Seeing	☐	☐
2. Hearing	☐	☐
3. Speaking	☐	☐

4. Describe how the faculties checked "limited" are impaired.

ATTENTION/CONCENTRATION

Is it medically reasonable to expect that this patient's ability to maintain attention and concentration on work tasks throughout an 8 hour day is significantly compromised by pain. prescribed medication or both?

ENVIRONMENTAL LIMITATIONS

Are the following **ENVIRONMENTAL LIMITATIONS** caused by the impairment?

	LIMITED	UNLIMITED
1. Temperature Extremes	☐	☐
2. Noise	☐	☐
3. Dust	☐	☐
4. Vibration	☐	☐
5. Humidity/Wetness	☐	☐
6. Hazards (machinery, heights, ...)	☐	☐
7. Fumes, odors, chemicals, gases	☐	☐

8. Describe how the environment factors impair activities and identify hazards to be avoided. What medical/clinical findings support your conclusions?

Physician's Signature _____ Medical Specialty _____ Date _____

PRIVACY ACT STATEMENT

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(6), 1614(a)(3)(h)(1) and1631(d)(1) of the Social Security Act. The information on this form is needed by Social Security to complete processing of the named patient's claim. While giving us the information on this form is voluntary, failure to provide the requested information may prevent an accurate or timely decision on the named patient's claim. Although the information you furnish on this form is almost never used for any purpose other than making a determination about disability, such information may be disclosed by Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws requiring the exchange information between Social Security and another agency.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by Section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 15 minutes to read the instructions, gather the facts, and answer the questions. *You may send comments on our time estimate above to: SSA. 1338 Annex Building, Baltimore, MD 21235-6401.* ***Send only comments relating to our time estimate to this address, not the completed form.***

MEDICAL ASSESSMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES
(MENTAL) – Consultative Examiner

Name of Individual _____ Social Security Number _____

To determine this individual's ability to do work-related activities on a day-to-day basis in a regular work setting, please give us an assessment-BASED ON YOUR EXAMINATION- of how the individual's mental/emotional capabilities are affected by the impairment(s). Consider the medical history, the chronicity of findings (or lack thereof), and the expected duration of any work-related limitations, but not the individual's age, sex or work experience.

I. For each activity shown below, check the block that best describes the individual's psychological limitations in performing work related tasks. The range is from no limitation to an extreme limitation. NOTE: A marked limitation is such as to seriously interfere with the ability to function independently, appropriately and effectively. Where "marked" is used as the degree of limitation, it means more than moderate, but less than extreme:

A. OCCUPATIONAL ADJUSTMENTS

	NONE	SLIGHT	MODERATE	MARKED	EXTREME
1. Follow Work Rules					
2. Relate to co-workers					
3. Deal with the public					
4. Use Judgment					
5. Interact with Supervisor					
6. Deal with work stresses					
7. Function independently					
8. Maintain attention/ concentration					

B. MAKING PERFORMANCE ADJUSTMENTS

	NONE	SLIGHT	MODERATE	MARKED	EXTREME
1. Understand, remember and carry out complex job instructions					
2. Understand, remember, and carry out detailed, but not complex, job instructions					
3. Understand, remember and carry out simple job instructions.					

C. MAKING PERSONAL-SOCIAL ADJUSTMENTS

	NONE	SLIGHT	MODERATE	MARKED	EXTREME
1. Maintain personal appearance					
2. Behave in an emotionally stable manner					
3. Relate predictably in social situations					
4. Demonstrate reliability					

II. OTHER WORK-RELATED ACTIVITIES

Please identify any other work-related activities which are affected by the impairment(s), and indicate how the activities are affected.

III. Please provide your DSM-III-R diagnosis(es) and the significant medical or clinical findings (i.e., mental status examination, behavior, intelligence test results, symptoms) which support your assessment of any limitations.

IV. CAPABILITY TO MANAGE BENEFITS

Can the individual manage benefits in his or her own best interest? YES [ ] NO [ ]

SIGNATURE/TITLE/MEDICAL SPECIALTY DATE