FIBROMYALGIA
MEDICAL SOURCE STATEMENT

To: _____

Re: _____(Name of Patient)

_____(Social Security No.)

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. Does your patient meet the American College of Rheumatology criteria for fibromyalgia?
__ Yes __ No

3. List any other diagnosed impairments: _____

_____

4. Prognosis: _____

5. Have your patient's impairments lasted or can they be expected to last at least twelve months?
__ Yes __ No

6. Identify the *clinical findings*, laboratory and test results that show your patient's medical impairments: _____

_____

7. Identify all of your patient's symptoms:

- __ Multiple tender points
- __ Nonrestorative sleep
- __ Chronic fatigue
- __ Morning stiffness
- __ Muscle weakness
- __ Subjective swelling
- __ Irritable Bowel Syndrome
- __ Frequent, severe headaches
- __ Female Urethral Syndrome
- __ Premenstrual Syndrome (PMS)
- __ Vestibular dysfunction
- __ Temporomandibular Joint Dysfunction (TMJ)
- __ Numbness and tingling
- __ Sicca symptoms
- __ Raynaud's Phenomenon
- __ Dysmenorrhea
- __ Breathlessness
- __ Anxiety
- __ Panic attacks
- __ Depression
- __ Mitral Valve Prolapse
- __ Hypothyroidism
- __ Carpal Tunnel Syndrome
- __ Chronic Fatigue Syndrome

8. Is your patient a malingerer? __ Yes __ No

9. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? __ Yes __ No

10. If your patient has pain:

a. Identify the location of pain including, where appropriate, an indication of right or left side or bilateral areas affected:

	RIGHT	LEFT	BILATERAL
__ Lumbosacral spine	__	__	__
__ Cervical spine	__	__	__
__ Thoracic spine	__	__	__
__ Chest	__	__	__
__ Shoulders	__	__	__
__ Arms	__	__	__
__ Hands/fingers	__	__	__
__ Hips	__	__	__
__ Legs	__	__	__
__ Knees/ankles/feet	__	__	__

b. Describe the nature, frequency, and severity of your patient's pain:

_____

_____

c. Identify any factors that precipitate pain:

__ Changing weather __ Fatigue __ Movement/Overuse __ Cold
__ Stress __ Hormonal Changes __ Static Position

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 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.

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

__ Incapable of even "low stress" jobs __ Capable of low stress jobs
__ Moderate stress is okay __ Capable of high stress work

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

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
__	__	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?

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. While engaging in occasional standing/walking, must your patient use a cane or other assistive device? __ Yes __ No

h. 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? _____
3) on such a break, will your patient need to __ lie down or __ sit quietly?

i. 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? _____%

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
Twist	—	—	—	—
Stoop (bend)	—	—	—	—
Crouch/ squat	—	—	—	—
Climb ladders	—	—	—	—
Climb stairs	—	—	—	—

l. 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	—	—	—	—

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 that would affect your patient's ability to work at a regular job on a sustained basis.

17. What is the ealiest date the description of *symptoms and limitations* on this questionnaire applies?_____

Date:_____

_____
Signature

Print/Type Name: _____

Address: _____

_____