MANIPULATIVE LIMITATIONS MEDICAL SOURCE STATEMENT

From: _____

Re: _____ (Name of Patient)

_____ (Social Security No.)

1. Identify any signs or symptoms your patient exhibits that affect shoulders, elbows, wrists, hands or fingers:

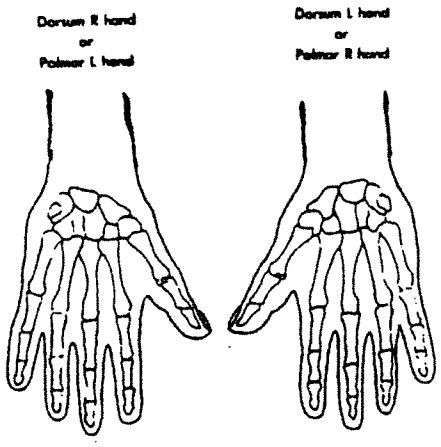
☐ tenderness	☐ paresthesia	☐ joint warmth
☐ pain	☐ soft tissue swelling	☐ joint deformity
☐ muscle spasm	☐ muscle weakness	☐ reduced grip strength
☐ redness	☐ limitation of motion	☐ muscle atrophy

☐ other:_____

2. If your patient has pain/paresthesia, please characterize the nature of the pain/paresthesia:_____

_____

3. Please identify the location and frequency of pain/paresthesia by shading the relevant areas and labeling as constant (C), frequent (F), or intermittent (I):



4. Please state any weight lifting limitations:

Left arm: _____ Right arm: _____ Both: _____

5. 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 In Front of Body**	**ARMS: Reaching Overhead**
Right:	**%**	**%**	**%**	**%**
Left:	**%**	**%**	**%**	**%**

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____

_____

7-29
8/09
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