

MENTAL IMPAIRMENT QUESTIONNAIRE

To: Social Security Administration

Re: _____

SSN: _____

Please answer the following questions concerning your patient's impairments

1. How long have you been treating your patient:

2. What is your diagnosis:

3. Identify your patient's signs and symptoms:

Short term, intermediate or long term memory impairment	Oddities of thought, perception, speech and behavior
Appetite disturbance with weight change	Perceptual disturbances
Sleep disturbance	Time or place disorientation
Personality change	Catatonia or grossly disorganized behavior
Persistent disturbances of mood or affect	Emotional withdrawal and/or isolation
Emotional lability and impairment in impulse control	Blunt or flat or inappropriate affect
Loss of intellectual ability of 15 IQ points or more	Incoherence, loosening of association, illogical thinking or poverty of content of speech
Delusions, hallucinations or paranoid thinking	Hyperactivity
Decreased energy	Pressure of speech
Flight of ideas	Inflated self-esteem
Decreased need for sleep	Easy distractibility
Involvement in activities that have a high probability of painful consequences which are not recognized	Motor tension
Autonomic hyperactivity	Apprehensive expectation
Vigilance or scanning	Persistent irrational fear of a specific object, activity or situation which results in a compelling desire to avoid the dreaded object, activity or situation
Recurrent severe panic attacks manifested by a	Recurrent obsessions or compulsions which are a

sudden unpredictable onset of intense apprehension, occurring on the average of at least once a week	source of marked distress
Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress	Nonorganic disturbance of vision or speech or hearing or use of a limb, or movement and its control, or sensation
Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury	Seclusiveness or autistic thinking
Pathologically inappropriate suspiciousness or hostility	Pathological dependence, passivity, or aggressivity
Intense and unstable interpersonal relationships and impulsive and damaging behavior	Qualitative deficits in reciprocal social interactions
Qualitative deficits in verbal and nonverbal communication and in imaginative activity	Marked restricted repertoire of activities and interests

Other symptoms and remarks:

4. Describe the *clinical findings* including results of mental status examination which demonstrate the severity of your patient's mental impairment and symptoms:

5. Describe any side effects of medications that may have implications for daily and/or social functioning. e.g., dizziness, drowsiness, fatigue, lethargy, stomach upset, etc.:

6. Indicate to what degree the following functional limitations are imposed upon by your patient's mental impairments.

The ability to remember locations and work-like procedures.	None	Slight	Moderate	Marked*	Extreme
The ability to understand, remember and carry out simple instructions.	None	Slight	Moderate	Marked*	Extreme
The ability to maintain attention and concentration for extended periods.	None	Slight	Moderate	Marked*	Extreme
The ability to perform activities within a schedule, be punctual and maintain regular attendance.	None	Slight	Moderate	Marked*	Extreme
The ability to work in coordination with or	None	Slight	Moderate	Marked*	Extreme

proximity to others without being distracted					
The ability to make a simple work related decisions	None	Slight	Moderate	Marked*	Extreme
The ability to interact appropriately with the general public	None	Slight	Moderate	Marked*	Extreme
The ability to accept instructions and respond appropriately to criticism from supervisors.	None	Slight	Moderate	Marked*	Extreme
The ability to get along with coworkers without distracting them or exhibiting extreme behaviors	None	Slight	Moderate	Marked*	Extreme
The ability to maintain socially appropriate behavior and adhere to basic standards of neatness/cleanliness	None	Slight	Moderate	Marked*	Extreme
The ability to respond appropriately to changes in the work setting.	None	Slight	Moderate	Marked*	Extreme

**Note:* Marked is a standard used for measuring the degree of limitation. It means more than moderate, but less than extreme.

7. On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?

Never About once a month About three times a month
 Less than once a month About twice a month More than three times a month

8. In your professional opinion, is your patient capable of performing a full-time job, working 8 hours a day, 5 days per week, on a regular and continuing basis?

Yes. No.



Date _____

Signature _____
Treating Psychologist/Psychiatrist
Printed/Typed Name:

Address:

Please return to:

