Medical Assessment Form

Patient: ______________________
SSN: ________________________

Please answer each of the following questions about the patient. They concern the patient's claim of entitlement to disability benefits under the Social Security Act. Since this form will be used by the Social Security Administration in deciding if the patient is disabled, please make sure that it is legible and that every question is answered completely. If a question is not applicable to the patient, please so indicate.

1. Dates of treatment:

First _____________ Last _____________ Frequency ____

2. Diagnoses:

____
____
____
____
____
____

3. Brief medical history:

____
____
____
____
____
____

4. Pertinent physical findings including:

a. Results of tests performed on patient, including dates and specific findings:

____
____
____
____
____

b. Clinical findings and observations:

____
____
____
____

5. Describe in detail the patient's symptoms (including fatigue, weakness, pain, nausea, vomiting, diarrhea, weight loss, insomnia, memory loss, concentration deficits, neuropathy, anemia, herpes outbreaks, etc.):

____
____
____
____
____
____

6. Is it reasonable to expect these symptoms given the objective medical findings? ____ Yes _____ No

____
____

7. Treatment and medications prescribed with dosage, frequency and response:

____
____
____
____
____

8. Does any medication have side effects or limit the patient's activities? _____ Yes _____ No. If yes, explain:

____
____
____

9. Have any of your patient's medical conditions lasted or can any be expected to last at least twelve months?
_____ Yes _____ No

____
____
____

10. Prognosis: ____
____
____

11. Does or could any medical condition cause your patient pain? _____ Yes ______ No. If yes, explain:

____
____
____

12. Does the patient require a work accommodation to sit and stand at will due to pain? ____ Yes ____ No

13. Does the patient have to lie down during the day? _____ Yes _____ No
If yes, for how long and for what reason:

____
____
____

14. Could your patient travel alone to work on a daily basis:

(a) By bus? _____ Yes _____ No

(b) By subway? _____ Yes _____ No

15. Please answer each question by estimating the degree of your patient's ability to do the following on a daily basis in a **work place setting** (taking into account pain and medication side effects):

(a) In an 8-hour workday your patient can:

Sit a total of _____ hours in an 8-hour workday.

Stand and/or Walk a total of _____ hours in an 8-hour workday.

16. Please estimate the degree of your patient's ability to do the following on a daily basis in a **work place setting** (taking into account pain and medication side effects).

Occasionally means 1% - 33%; Frequently means 34% - 66%; Continuously means 67% - 100%

In an 8-hour workday your patient can:

Lift:

	Never	Occasionally	Frequently	Continuously
Up to 5	_____	_____	_____	_____
6-10	_____	_____	_____	_____
11-20	_____	_____	_____	_____
21-50	_____	_____	_____	_____
51-100	_____	_____	_____	_____

Carry:

	Never	Occasionally	Frequently	Continuously
Up to 5	_____	_____	_____	_____
6-10	_____	_____	_____	_____
11-20	_____	_____	_____	_____
21-50	_____	_____	_____	_____
51-100	_____	_____	_____	_____

	Never	Occasionally	Frequently	Continuously
Stoop	_____	_____	_____	_____
Kneel	_____	_____	_____	_____
Crouch	_____	_____	_____	_____
Crawl	_____	_____	_____	_____
Climb	_____	_____	_____	_____
Balance	_____	_____	_____	_____

Use hands and/or arms for repetitive action, such as:

	Never	Occasionally	Frequently	Continuously
Handling (gross manipulation)				
Right	_____	_____	_____	_____
Left	_____	_____	_____	_____
Fingering (fine manipulation)				
Right	_____	_____	_____	_____
Left	_____	_____	_____	_____
Reaching (extending hands & arms in any direction)				
Right	_____	_____	_____	_____
Left	_____	_____	_____	_____
Pushing and Pulling of Arm Controls				
Right	_____	_____	_____	_____
Left	_____	_____	_____	_____

Use feet for repetitive movements, such as pushing and pulling of leg controls:

	Never	Occasionally	Frequently	Continuously
Right	_____	_____	_____	_____
Left	_____	_____	_____	_____
Both	_____	_____	_____	_____

17. The patient has restrictions involving:

	None	Mild	Moderate	Total Restriction
Exposure to dusts, fumes, gases, noxious odors and poor ventilation	_____	______	______	______
Exposure to marked changes in temperature and humidity	_____	______	______	______
Being around moving machinery	_____	______	______	______
Unprotected heights	_____	______	______	______
Driving a motor vehicle	_____	______	______	______

Explain or add any other restrictions:

____

____

____

____

18. Does your patient demonstrate any emotional or mental limitations (such as anxiety, depression, decreased concentration, memory problems, insomnia, or appetite loss) which impact their medical condition? Please specify. ____ Yes ____ No

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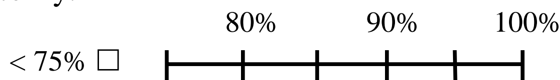
____

____

19. Does your patient have any physical or mental limitations, including the impact of pain, which could cause them to be off task during the course of an 8 hour workday? ____ Yes ____ No

If yes, please indicate below the amount of an 8-hour workday that the patient can maintain attention/ concentration satisfactorily:



20. Are your patient's limitations, when considered in combination, likely to produce "good" days and "bad" days? ____ Yes ____ No

If yes, please estimate, on average, how many days per month your patient is likely to be absent from work as a result of the impairments, or as a result of necessary medical treatment:

____ Never
____ About 1 day per month
____ About 2 days per month
____ About 3 days per month
____ About 4 days per month
____ More than 4 days per month

21. Additional comments:

____

____

____

____

____

____

Signature: ______________________________ Date: ____________________
Printed Name: ______________________________
Hospital: ______________________________
Address: ______________________________
____
Phone: ______________________________

If form is not completed by a physician, please have supervising physician review and co-sign the form below.

Signature: ______________________________ Date: ____________________
Printed Name: ______________________________ Title: ____________________