Medical Source Statement Concerning the Nature and Severity of an Individual's Mental Impairment

NAME OF INDIVIDUAL:_____ **SSN:** _____

NAME OF HEALTH CARE PROFESSIONAL: _____

In responding to the designated ratings of the following categories of mental functioning, it is essential that your responses and comments be based on your clinical assessment of the individual's current and past mental limitations and not on non-medical factors. For example, your assessment should *not* be based on such non-medical factors as the availability of job openings, the hiring practices of employers, cyclical economic conditions, technological changes in the work industry since the individual last worked, or upon the individual's preference not to do a particular type of work. (*See*, 20 CFR §§ 404.1566(c) & 416.966(c).)

Special Note Regarding Drug Addiction and/or Alcoholism: In responding to the ratings on this form, please do not include any limitations which you believe the individual has as a result of his or her alcoholism and/or drug addiction, if any. In other words, *do not include limitations which would go away if the individual stopped using drugs or alcohol.*

Among other things, the following assessment form reflects the four criteria in Social Security Administration regulations concerning the mental ability to do basic work activity. (*See*, 20 CFR §§ 404.1521 & 416.921.) *These four criteria, as well as those for other than "basic" work activities, are to be documented and evaluated in terms of the individual's maximum remaining ability to perform sustained work on a regular and continuing basis; i.e., 8 hours a day, for 5 days a week, or an equivalent work schedule.*

DEFINITIONS OF RATING TERMS

Not Significantly Limited: No significant limitation in this area.

Mildly Limited: An impairment which mildly limits the individual's ability to perform the designated activity on a regular and sustained basis, *i.e.*, 8 hours a day, 5 days a week, or an equivalent work schedule.

Moderately Limited: An impairment which seriously interferes with the individual's ability to perform the designated activity on a regular and sustained basis, *i.e.*, 8 hours a day, 5 days a week, or an equivalent work schedule.

Markedly Limited: An impairment which precludes the individual's ability to function independently, appropriately, and effectively in the designated area on a regular and sustained basis, *i.e.*, 8 hours a day, 5 days a week, or an equivalent work schedule.

Using the above-listed **DEFINITIONS OF RATING TERMS** to assess the degree of limitation the individual experiences in the categories of mental functioning set out below, please record your professional opinion by placing a check mark or X in the corresponding boxes.

UNDERSTANDING AND MEMORY:	Not Significantly Limited	Mildly Limited	Moderately Limited	Markedly Limited
1. The ability to remember locations and work-like procedures.	☐	☐	☐	☐
2. The ability to understand and remember very short and simple instructions.	☐	☐	☐	☐
3. The ability to understand and remember detailed instructions.	☐	☐	☐	☐

SUSTAINED CONCENTRATION AND PERSISTENCE:	Not Significantly Limited	Mildly Limited	Moderately Limited	Markedly Limited
4. The ability to carry out short and simple instructions.	☐	☐	☐	☐
5. The ability to carry out detailed instructions.	☐	☐	☐	☐
6. The ability to maintain attention and concentration for extended periods (the approximately 2-hour segments between arrival and first break, lunch, second break, and departure).	☐	☐	☐	☐
7. The ability to perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances.	☐	☐	☐	☐
8. The ability to sustain an ordinary routine without special supervision.	☐	☐	☐	☐
9. The ability to work in coordination with or proximity to others without being unduly distracted by them.	☐	☐	☐	☐
10. The ability to make simple work-related decisions.	☐	☐	☐	☐
11. The ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	☐	☐	☐	☐

SOCIAL INTERACTION:

12. The ability to interact appropriately with the general public.	☐	☐	☐	☐
13. The ability to ask simple questions or request assistance.	☐	☐	☐	☐
14. The ability to accept instructions and to respond appropriately to criticism from supervisors.	☐	☐	☐	☐
15. The ability to get along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes.	☐	☐	☐	☐
16. The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	☐	☐	☐	☐

ADAPTATION:	Not Significantly Limited	Mildly Limited	Moderately Limited	Markedly Limited
17. The ability to respond appropriately to changes in the work setting.	☐	☐	☐	☐
18. The ability to be aware of normal hazards and take appropriate precautions.	☐	☐	☐	☐
19. The ability to travel in unfamiliar places or to use public transportation.	☐	☐	☐	☐
20. The ability to set realistic goals or to make plans independently of others.	☐	☐	☐	☐

QUESTION A: (DURATION OF ASSESSED LIMITATIONS)

The Patient/Claimant, _____, states that her limitations in the above areas began on or around _____.

In your opinion, have the limitations assessed on this form lasted 12 continuous months **or** can they be expected to last 12 continuous months *at the assessed severity*?

YES ☐ **NO** ☐

QUESTION B: (ONSET OF ASSESSED LIMITATIONS)

Based upon your evaluation, treatment, and/or review of records, please state the earliest date from which the limitations assessed on this form have existed *at the assessed severity*.

DATE OF ONSET OF THE FOREGOING LIMITATIONS: _____

COMMENTS

In the space below, or in a separate writing if you prefer, please state any clarifying comments you wish to make, then please sign your name, and date the form where designated at the bottom of the page.

X _____ _____

SIGNATURE Psychologist/Psychiatrist **DATE**

_____

Printed

_____

Title/Medical Designation/Specialty

X _____ _____

SIGNATURE OF Therapist/Counselor **DATE**

_____

Printed

_____

Title/Medical Designation/Specialty

X _____ _____

SIGNATURE OF Other Health Care Prof'l **DATE**

_____

Printed

_____

Title/Medical Designation/Specialty