

INSTRUCTIONS FOR THE
MENTAL HEALTH
MEDICAL SOURCE STATEMENT FORM

1. **Do not** write on this form yourself.
2. Take this form to the doctor that knows the most about all of your conditions.
3. You should not be in the room when the doctor fills it out and you should not directly answer the questions on the form for the doctor. The doctor needs to complete the form **independently** of you.
4. A **MD** (psychiatrist) or **PhD** (psychologist) ***must*** sign this form in order for it to be accepted by Social Security.
5. If you see a therapist they may fill out the report and sign it, but an MD or PhD must still co-sign the report.
6. We cannot force your doctor to complete the report.
7. You may return this report to us or the doctor may return the report by fax to 702-800-5408

**MENTAL IMPAIRMENT QUESTIONNAIRE
(RFC & LISTINGS)**

To: _____ Re: _____

SSN: _____

Please answer the following questions concerning your patient's impairments. *Attach relevant treatment notes and test results* as appropriate.

1. Frequency and length of contact: _____

2. DSM-V Diagnoses: _____

3. Treatment and response: _____

4. a. List of prescribed medications: _____

b. Describe any side effects of medications that may have implications for working. E.g., dizziness, drowsiness, fatigue, lethargy, stomach upset, etc.:

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

6. Prognosis: _____

7. Identify your patient's signs and symptoms:

Anhedonia or pervasive loss of interest in almost all activities	Intense and unstable interpersonal relationships and impulsive and damaging behavior
Appetite disturbance with weight change	Disorientation to time and place
Decreased energy	Perceptual or thinking disturbances
Thoughts of suicide	Hallucinations or delusions
Blunt, flat or inappropriate affect	Hyperactivity
Feelings of guilt or worthlessness	Motor tension
Impairment in impulse control	Catatonic or other grossly disorganized behavior
Poverty of content of speech	Emotional lability
Generalized persistent anxiety	Flight of ideas
Somatization unexplained by organic disturbance	Manic syndrome
Mood disturbance	Deeply ingrained, maladaptive patterns of behavior
Difficulty thinking or concentrating	Inflated self-esteem
Recurrent and intrusive recollections of a traumatic experience, which are a source of marked distress	Unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that one has a serious disease or injury
Psychomotor agitation or retardation	Loosening of associations
Pathological dependence, passivity or aggression	Illogical thinking
Persistent disturbances of mood or affect	Vigilance and scanning
Persistent nonorganic disturbance of vision, speech, hearing, use of a limb, movement and its control, or sensation	Pathologically inappropriate suspiciousness or hostility
Change in personality	Pressures of speech
Apprehensive expectation	Easy distractibility
Paranoid thinking or inappropriate suspiciousness	Autonomic hyperactivity
Recurrent obsessions or compulsions which are a source of marked distress	Memory impairment – short, intermediate, or long term
Seclusiveness or autistic thinking	Sleep disturbance
Substance dependence	Oddities of thought, perception, speech, or behavior
Incoherence	Decreased need for sleep
Emotional withdrawal or isolation	Loss of intellectual ability of 15 IQ points or more
Psychological or behavioral abnormalities associated with a dysfunction of the brain with a specific organic factor judged to be etiologically related to the abnormal mental state and loss of previously acquired functional abilities	Recurrent severe panic attacks manifested by a sudden unpredictable onset of intense apprehension, fear, terror, and sense of impending doom occurring on the average of at least once a week
Bipolar syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes)	A history of multiple physical symptoms (for which there are no organic findings) of several years' duration beginning before age 30, that have caused the individual to take medicine frequently, see a physician often and alter life patterns significantly
Persistent irrational fear of a specific object, activity, or situation which results in a compelling desire to avoid the dreaded object, activity, or situation	Involvement in activities that have a high probability of painful consequences which are not recognized

8. To determine your patient's ability to do *work-related activities on a day-to-day basis in a regular work setting*, please give us your opinion **based on your examination** of how your patient's mental/emotional capabilities are affected by the impairment(s). Consider the medical history, the chronicity of findings (or lack thereof), and the expected duration of any work-related limitations, but not your patient's age, sex or work experience.

- *Seriously limited, but not precluded* means ability to function in this area is seriously limited and less than satisfactory, but not precluded in all circumstances. Limited 10% to 25% of the time.
- *Unable to meet competitive standards* means your patient cannot satisfactorily perform this activity independently, appropriately, effectively and on a sustained basis in a regular work setting. Limited 26% to 49% of the time.
- *No useful ability to function*, an extreme limitation, means your patient cannot perform this activity in a regular work setting. Limited more than 50% of the time.

10% to 25% 26% to 49% 50% or more

I.	MENTAL ABILITIES AND APTITUDES NEEDED TO DO UNSKILLED WORK	Unlimited or Very Good	Limited but satisfactory	Seriously limited, but not precluded	Unable to meet competitive standards	No useful ability to function
A.	Remember work-like procedures					
B.	Understand and remember very short and simple instructions					
C.	Carry out very short and simple instructions					
D.	Maintain attention for two-hour segment					
E.	Maintain regular attendance and be punctual within customary, usually strict tolerances					
F.	Sustain an ordinary routine without special supervision					
G.	Work in coordination with or proximity to others without being unduly distracted					
H.	Make simple work-related decisions					
I.	Complete a normal workday and workweek without interruptions from psychologically based symptoms					
J.	Perform at a consistent pace without an unreasonable number and length of rest periods					
K.	Ask simple questions or request assistance					
L.	Accept instructions and respond appropriately to criticism from supervisors					
M.	Get along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes					
N.	Respond appropriately to changes in a routine work setting					
O.	Deal with normal work stress					
P.	Be aware of normal hazards and take appropriate precautions					

Explain limitations falling in the three most limited categories (identified by **bold type**) and include the medical/clinical findings that support this assessment:

10% to 25% 26% to 49% 50% or more

II.	MENTAL ABILITIES AND APTITUDES NEEDED TO DO SEMISKILLED AND SKILLED WORK	Unlimited or Very Good	Limited but satisfactory	Seriously limited, but not precluded	Unable to meet competitive standards	No useful ability to function
A.	Understand and remember detailed instructions					
B.	Carry out detailed instructions					
C.	Set realistic goals or make plans independently of others					
D.	Deal with stress of semiskilled and skilled work					

Explain limitations falling in the three most limited categories (identified by **bold type**) and include the medical/clinical findings that support this assessment:

10% to 25% 26% to 49% 50% or more

III.	MENTAL ABILITIES AND APTITUDE NEEDED TO DO PARTICULAR TYPES OF JOBS	Unlimited or Very Good	Limited but satisfactory	Seriously limited, but not precluded	Unable to meet competitive standards	No useful ability to function
A.	Interact appropriately with the general public					
B.	Maintain socially appropriate behavior					
C.	Adhere to basic standards of neatness and cleanliness					
D.	Travel in unfamiliar place					
E.	Use public transportation					

Explain limitations falling in the three most limited categories (identified by **bold type**) and include the medical/clinical findings that support this assessment:

9. Does your patient have a low IQ or reduced intellectual functioning? Yes No

Please explain (with reference to specific test results):

10. Does the psychiatric condition exacerbate your patient's experience of pain or any other physical symptom? Yes No

If yes, please explain: _____

11. Indicate to what degree the following functional limitations exist as a result of your patient's mental impairments. *Note: **Marked** means more than moderate but less than extreme. A marked limitation may arise when several activities or functions are impaired or even when only one is impaired, so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, effectively, and on a sustained basis.*

FUNCTIONAL LIMITATION					
A.	Restriction of activities of daily living	None-Mild —	Moderate —	Marked —	Extreme —
B.	Difficulties in maintaining social functioning	None-Mild —	Moderate —	Marked —	Extreme —
C.	Difficulties in maintaining concentration, persistence, or pace	None-Mild —	Moderate —	Marked —	Extreme —
D.	Episodes of decompensation* within 12-month period, each of at least two weeks duration**	None —	One or Two —	Three —	Four or More —

* Episodes of decompensation are exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning, as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence, or pace. Episodes of decompensation may be demonstrated by an exacerbation of symptoms or signs that would ordinarily require increased treatment or a less stressful situation (or a combination of the two).

** If within one year your patient had more than three episodes of decompensation of shorter duration than two weeks or less frequent episodes of decompensation of longer duration than two weeks, please give the approximate dates of each episode of decompensation:

12. Please indicate if any of the following apply to your patient:

- A. Medically documented history of a chronic organic mental, schizophrenic, etc., or affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do any basic work activity, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:
1. Three or more episodes of decompensation within 12 months, each at least two weeks long.
 2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate.
 3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement with an indication of continued need for such an arrangement.
- B. An anxiety related disorder and **complete** inability to function independently outside the area of one's home.

13. 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 two days per month About four days per month
 About one day per month About three days per month More than four days per month

14. Has your patient's impairment lasted or can it be expected to last at least twelve months? Yes No

15. Is your patient a malingerer? Yes No

16. Are your patient's impairments reasonably consistent with the symptoms and functional limitations described in this evaluation?

If no, please explain: _____

17. Please describe any additional reasons not covered above why your patient would have difficulty working at a regular job on a sustained basis.

18. If your patient's impairments include alcohol or substance abuse, do alcohol or substance abuse contribute to any of your patient's limitations set forth above? Yes No

If Yes, a) please list the limitations affected:

b) please explain what changes you would make to your description of your patient's limitations if your patient were totally abstinent from alcohol or substance abuse:

19. Would physical exercise alleviate the patient's depression symptoms to a substantial degree? Yes No

20. Can your patient manage benefits in his or her own best interest? Yes No

Date

Signature

Printed/Typed Name: _____

Address: _____

* This form was provided by Representative in blank to the medical provider or claimant without comment as to how the form should be completed and no suggestion as to answers for the form was given to either the medical provider or claimant. The claimant was not referred to this provider by the Representative.

[20 CFR § 404.1740(b)(5) & 416.1540(b)(5)]