

**TREATING PHYSICIAN'S MEDICAL SOURCE STATEMENT  
FIBROMYALGIA - QUESTIONNAIRE**

To: \_\_\_\_\_

Re: \_\_\_\_\_ (Name of Patient)

\_\_\_\_\_ (Social Security No.)

Please answer the following questions concerning your patient's impairments. *Attach all relevant treatment notes, radiologist reports, laboratory and test results which have not been provided previously to the Social Security Administration.*

1. Nature, frequency and length of contact: \_\_\_\_\_

2. Does your patient meet the American Rheumatological criteria for fibromyalgia?

Yes    No

3. List any other diagnosed impairments:

\_\_\_\_\_  
\_\_\_\_\_

4. Prognosis:

\_\_\_\_\_  
\_\_\_\_\_

5. Have your patient's impairments lasted or can they be expected to last at least twelve months?

Yes    No

6. Identify the *clinical findings*, laboratory and test results which show your patient's medical impairments:

\_\_\_\_\_  
\_\_\_\_\_

7. Identify all of your patient's symptoms:

- |                          |   |                          |                          |
|--------------------------|---|--------------------------|--------------------------|
| <input type="checkbox"/> | Multiple tender points                    | <input type="checkbox"/> | Numbness and tingling    |
| <input type="checkbox"/> | Nonrestorative sleep                      | <input type="checkbox"/> | Sicca symptoms           |
| <input type="checkbox"/> | Chronic fatigue                           | <input type="checkbox"/> | Raynaud's Phenomenon     |
| <input type="checkbox"/> | Morning stiffness                         | <input type="checkbox"/> | Dysmenorrhea             |
| <input type="checkbox"/> | Muscle weakness                           | <input type="checkbox"/> | Breathlessness           |
| <input type="checkbox"/> | Subjective swelling                       | <input type="checkbox"/> | Anxiety                  |
| <input type="checkbox"/> | Irritable Bowel Syndrome                  | <input type="checkbox"/> | Panic attacks            |
| <input type="checkbox"/> | Frequent, severe headaches                | <input type="checkbox"/> | Depression               |
| <input type="checkbox"/> | Female Urethral Syndrome                  | <input type="checkbox"/> | Mitral Valve Prolapse    |
| <input type="checkbox"/> | Premenstrual Syndrome (PMS)               | <input type="checkbox"/> | Hypothyroidism           |
| <input type="checkbox"/> | Vestibular dysfunction                    | <input type="checkbox"/> | Carpal Tunnel Syndrome   |
| <input type="checkbox"/> | Temporomandibular Joint Dysfunction (TMJ) | <input type="checkbox"/> | Chronic Fatigue Syndrome |

8. Is your patient a malingerer?

Yes No

9. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?

Yes No

10. If your patient has pain:

a. Identify the location of pain including, where appropriate, an indication of right or left side or bilateral areas affected:

		RIGHT	LEFT	BILATERAL
	Lumbosacral spine			
	Cervical spine			
	Thoracic spine			
	Chest			
	Shoulders			
	Arms			
	Hands/fingers			
	Hips			
	Legs			
	Knees/ankles/feet			

b. Describe the nature, frequency, and severity of your patient's pain:

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c. Identify any factors that precipitate pain:

Changing Weather	Fatigue	Movement/Overuse	Stress
Cold	Hormonal Changes	Static Position	

11. Are your patient's impairments (physical impairments plus any emotional impairments) *reasonably consistent* with the symptoms and functional limitations described in this evaluation?

Yes No

If no, please explain:

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12. How often is your patient's experience of symptoms severe enough to interfere with attention and concentration?

Never Seldom Often Frequently Constantly

13. To what degree is your patient limited in the ability to deal with work stress?

\_\_\_ No limitation \_\_\_ Slight Limitation \_\_\_ Moderate Limitation  
 \_\_\_ Marked Limitation \_\_\_ Severe Limitation

14. Identify the side effects of any medication which may have implications for working, e.g., dizziness, drowsiness, stomach upset, etc.:

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15. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a *competitive work situation*:

a. How many city blocks can your patient walk without rest? \_\_\_\_\_

b. Please circle the hours and/or minutes that your patient can *continuously* sit and stand *at one time*:

1. **Sit:**  
0 5 10 15 20 30 45                      1 2 More than 2  
 Minutes    Hours

2. **Stand:**  
0 5 10 15 20 30 45                      1 2 More than 2  
 Minutes    Hours

c. Please indicate how long your patient can sit and stand/walk *total in an 8 hour working day* (with normal breaks):

Sit	Stand/walk	
_____	_____	less than 2 hours
_____	_____	about 2 hours
_____	_____	about 4 hours
_____	_____	at least 6 hours

d. Does your patient need to include periods of walking around during an 8 hour working day?

Yes    No

1. If yes, approximately how *often* must your patient walk?

1 5 10 15 20 30 45 60 90  
Minutes

2. How *long* must your patient walk each time?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15  
Minutes

e. Does your patient need a job which permits shifting positions *at will* from sitting, standing or walking?

Yes    No

f. Will your patient sometimes need to take unscheduled breaks during an 8 hour working day?

Yes    No

If yes, (1) how *often* do you think this will happen? \_\_\_\_\_

(2) how *long* (on average) will your patient have to rest before returning to work? \_\_\_\_\_

g. With prolonged sitting, should your patient's leg(s) be elevated?

Yes    No

If yes, (1) how *high* should the leg(s) be elevated? \_\_\_\_\_

(2) if your patient had a sedentary job, *what percentage of time* during an 8 hour working day should the leg(s) be elevated?

\_\_\_\_\_ %

h. While engaging in occasional standing/walking, must your patient use a cane or other assistive device?

Yes    No

i. How many pounds can your patient lift and carry in a competitive work situation?

	Never	Occasionally	Frequently
less than 10 lbs.	___	___	___
10 lbs.	___	___	___
20 lbs.	___	___	___
50 lbs.	___	___	___

*In an average 8 hour working day, "occasionally" means less than 1/3 of the working day; "frequently" means between 1/3 to 2/3 of the working day.*

j. Does your patient have *significant limitations* in doing *repetitive* reaching, handling or fingering?

Yes    No

If yes, please indicate the percentage of time during an 8 hour working day on a competitive job that your patient can use hands/fingers/arms for the following repetitive activities:

	HANDS: Grasp, Turn Twist Objects	FINGERS: Fine Manipulations	ARMS: Reaching (incl. Overhead)
Right:	%	%	%
Left:	%	%	%

k. Please state the percentage of time during an 8 hour working day that your patient can bend and twist at the waist.

Bend \_\_\_\_\_%    Twist \_\_\_\_\_%

l. Are your patient's impairments likely to produce "good days" and "bad days"?

Yes    No

If yes, please estimate, on the average, how often your patient is likely to be absent from work as a result of the impairments or treatment:

- |                            |                                   |
|----------------------------|-----------------------------------|
| ___ Never                  | ___ About twice a month           |
| ___ Less than once a month | ___ About three times a month     |
| ___ About once a month     | ___ More than three times a month |

16. What is the earliest date that the description of symptoms *and limitations* in this questionnaire applies?

17. Please attach an additional page to describe any other limitations that would affect your patient's ability to work at a regular job on a sustained basis.

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Signature*

*Printed/Typed Name:* \_\_\_\_\_

*Address:* \_\_\_\_\_

\_\_\_\_\_

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