

MEDICAL SOURCE STATEMENT
Mental Disorders

INSTRUCTIONS: Please complete the following statement based on your clinical evaluation and test findings. **You are not required to perform a functional capacity evaluation to render your opinion on this form.**

Patient Name: _____ Patient Since: _____ Frequency: _____

1. Diagnoses: _____

2. Does your patient have a medically determinable (i.e., found in the *DSM*) substance use disorder? Yes No
(If yes, would your patient still have the limitations listed below in the absence of drugs or alcohol?) Yes No

3. Symptoms (i.e., pain, dizziness, fatigue): _____

Describe the individual's ability to perform the activity according to the following terms.

Unlimited - Ability to function in this area is not limited by a mental impairment.

Good - Ability to function in this area is more than satisfactory.

Fair - Ability to function in this area is limited but satisfactory.

Poor - Ability to function in this area is seriously limited but not precluded.

None - No useful ability to function in this area.

Identify the particular medical or clinic findings (i.e., mental status examination, behavior intelligence test results, and symptoms) which support your assessment of any limitations.

I. MAKING OCCUPATIONAL ADJUSTMENTS

Check the blocks representing the individual's ability to adjust to a job and complete item #9.

| | UNLIMITED | GOOD | FAIR | POOR | NONE |
|--|------------------|-------------|-------------|-------------|-------------|
| 1. FOLLOW WORK RULES | | | | | |
| 2. RELATE TO CO-WORKERS | | | | | |
| 3. DEAL WITH THE PUBLIC | | | | | |
| 4. USE JUDGEMENT | | | | | |
| 5. INTERACT WITH SUPERVISOR(S) | | | | | |
| 6. DEAL WITH WORK STRESSES | | | | | |
| 7. FUNCTION INDEPENDENTLY | | | | | |
| 8. MAINTAIN ATTENTION/CONCENTRATION | | | | | |

9. Describe any limitations and include the medical/clinical findings that support this assessment.

II. MAKING PERFORMANCE ADJUSTMENTS

Check the blocks representing the individual’s ability to adjust to a job, and complete item #4.

| | UNLIMITED | GOOD | FAIR | POOR | NONE |
|--|------------------|-------------|-------------|-------------|-------------|
| 1. Understand, remember and carry out complex job instructions. | | | | | |
| 2. Understand, remember and carry out detailed, but not complex job instructions. | | | | | |
| 3. Understand, remember and carry out simple job instructions. | | | | | |

4. Describe any limitations and include the medical/clinical findings that support this assessment; e.g., intellectual ability, thought or organization, memory, comprehension, etc.

III. MAKING PERSONAL/SOCIAL ADJUSTMENTS

Check the blocks representing the individual’s ability to adjust personally and socially and complete item #5.

| | UNLIMITED | GOOD | FAIR | POOR | NONE |
|---|------------------|-------------|-------------|-------------|-------------|
| 1. Maintain personal appearance. | | | | | |
| 2. Behave in an emotionally stable manner. | | | | | |
| 3. Demonstrate reliability. | | | | | |

4. Describe any limitations and include the medical/clinical findings that support this assessment.

IV. OTHER WORK-RELATED ACTIVITIES

State any other work-related activities, which are affected by the impairment, and indicate how the activities are affected. What are the medical/clinical findings that support this assessment?

V. CAPABILITY TO MANAGE BENEFITS

Can the individual manage benefits in his or her own best interest? Yes No

SIGNATURE/TITLE/MEDICAL SPECIALITY

PRINTED NAME

DATE

Pursuant to 20 CFR §§ 404.1740(b)(5) and 416.1540(b)(5), please be advised that the questions on this statement were drafted by The Hicks Law Firm, PLLC (“HLF”). Furthermore, HLF advised the claimant to have this statement completed by his or her physician in order to strengthen his or her claim(s) for benefits. **HLF was not involved in the completion of the form.**