FIBROMYALGIA MEDICAL SOURCE STATEMENT

From: _____

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 as appropriate.*

1. Frequency and length of contact: _____

2. Does your patient meet the American College of Rheumatology 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 that show your patient's medical Impairments:

_____

7. Identify all of your patient's symptoms:

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

8. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? ☐ Yes ☐ No

9. 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:

_____

   c. Identify any factors that precipitate pain:

☐ Changing weather ☐ Fatigue ☐ Movement/Overuse ☐ Cold
☐ Stress ☐ Hormonal Changes ☐ Static Position

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

_____

11. 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 or severe pain? _____

   b. Please circle the hours and/or minutes that your patient can sit ***at one time***, e.g., before needing to get up, etc.

Sit: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

   c. Please circle the hours and/or minutes that your patient can stand ***at one time***, e.g., before needing to sit down, walk around, etc.

Stand: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

   d. 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

   e. Does your patient need a job that permits shifting positions ***at will*** from sitting, standing or walking? ☐ Yes ☐ No

f. 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

g. While engaging in occasional standing/walking, must your patient use a cane or other assistive device? ☐ Yes ☐ No

h. Will your patient sometimes need to take unscheduled breaks during a 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? _____
3) on such a break, will your patient need to ☐ lie down or ☐ sit quietly?

i. 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? _____ %

For this and other questions on this form, "rarely" means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.

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

	Never	**Rarely**	**Occasionally**	**Frequently**
Less than 10 lbs.		☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

k. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐
Crouch/ squat	☐	☐	☐	☐
Climb ladders	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐

l. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Look down (sustained flexion of neck)	☐	☐	☐	☐
Turn head right or left	☐	☐	☐	☐
Look up	☐	☐	☐	☐
Hold head in static position	☐	☐	☐	☐

m. If your patient has significant limitations with reaching, handling or fingering, please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn Twist Objects	**FINGERS: Fine Manipulations**	**ARMS: Reaching In Front of Body**	**ARMS: Reaching Overhead**
Right:	**%**	**%**	**%**	**%**
Left:	**%**	**%**	**%**	**%**

n. How much is your patient likely to be **"*off task*"**? That is, what percentage of a typical workday would your patient's symptoms likely be severe enough to interfere with ***attention and concentration*** needed to perform even simple work tasks?

☐ 0% ☐ 5% ☐ 10% ☐ 15% ☐ 20% ☐ 25% or more

o. To what degree can your patient tolerate work stress?

☐ Incapable of even "low stress" work ☐ Capable of low stress work
☐ Capable of moderate stress - normal work ☐ Capable of high stress work

p. Are your patient's impairments likely to produce "good days" and "bad days"?
☐ Yes ☐ No

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

☐ Never
☐ About one day per month
☐ About two days per month
☐ About three days per month
☐ About four days per month
☐ More than four days per month

12. Are your patient's impairments (physical impairments plus any emotional impairments) as demonstrated by signs, clinical findings and laboratory or test results ***reasonably consistent*** with the symptoms and functional limitations described above in this evaluation?
☐ Yes ☐ No

If no, please explain: _____

13. 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.

14. What is the ealiest date the description of ***symptoms and limitations*** on this questionnaire applies? _____

_____ _____
Date *Signature*

Print/Type Name: _____

Address: _____