MAJOR DYSFUNCTION OF JOINTS
TREATING PHYSICIAN
DATA SHEET

Short form

FOR REPRESENTATIVE USE ONLY

REPRESENTATIVE'S NAME AND ADDRESS

REPRESENTATIVE'S TELEPHONE

REPRESENTATIVE'S EMAIL

PHYSICIAN'S NAME AND ADDRESS

PHYSICIAN'S TELEPHONE

PHYSICIAN'S EMAIL

PATIENT'S NAME AND ADDRESS

PATIENT'S TELEPHONE

PATIENT'S EMAIL

PATIENT'S SSN

TYPE OF CLAIM:

Title 2 ☐ DIB/DWB ☐ CDB

Title 16 ☐ DI ☐ DC

LEVEL OF ADJUDICATION:

Initial DDS ☐ Recon DDS ☐

Initial CDR ☐ Hearing Officer ☐

Administrative Law Judge ☐ Appeals Council ☐

Federal District Court ☐ Federal Appeals Court ☐

Dear Dr.

We are pursuing the Social Security disability claim for the above-named individual (the "patient"). We understand how valuable your time is, and this data sheet has been designed to allow you to provide medical information in an efficient and organized way. As a treating physician, your records and medical judgment are vital in arguing for a fair disability determination for the patient before the Social Security Administration (SSA). If you receive multiple data sheets, please disregard repetitive questions.

Your medical specialty please:

Note 1: This document will not have legal validity for Social Security disability determination purposes unless completed by a licensed medical doctor or osteopath.

Note 2: This document only concerns joint dysfunction. Other impairments and limitations resulting from a combination of impairments should be considered separately.

Note 3: Age, degree of general physical conditioning, sex, body habitus (i.e., natural body build, physique, constitution, size, and weight), insofar as they are unrelated to the patient's medical disorder and symptoms, should not be considered when assessing the functional severity of the impairment.

"Occasionally" means very little up to 1/3 of an 8 hour workday.

"Frequently" means 1/3 to 2/3 of an 8 hour workday.

I. What is the medical impairment (rheumatoid arthritis, traumatic arthritis, osteoarthritis, etc.) causing joint dysfunction?

II. Is there a history of chronic joint pain and stiffness?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, when did the patient first complain to you of such symptoms?

Response of pain and stiffness to treatment:

- ☐ Complete symptomatic relief
- ☐ Partial symptomatic relief
- ☐ No symptomatic relief

III. In the affected joints, is there significant limitation of motion?

☐ **Yes** ☐ **No** ☐ **Unknown**

IV. Does the patient have gross anatomical deformity of any joint?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please check all that apply.

A. Hands/Wrist

☐ Ulnar deviation	☐ **One** or ☐ **both** hands?
☐ Swan-neck deformity	☐ **One** or ☐ **both** hands?
☐ Boutonniere deformity	☐ **One** or ☐ **both** hands?
☐ Contracture	☐ **One** or ☐ **both** hands?
☐ Bony or fibrous ankylosis	☐ **One** or ☐ **both** hands?
☐ Instability	☐ **One** or ☐ **both** hands?
☐ Other (please specify)	☐ **One** or ☐ **both** hands?

B. Elbows

☐ Contracture	☐ Left ☐ Right
☐ Bony or fibrous ankylosis	☐ Left ☐ Right
☐ Instability	☐ Left ☐ Right
☐ Other (please specify)	☐ Left ☐ Right

C. Shoulders

☐ Contracture	☐ Left ☐ Right
☐ Bony or fibrous ankylosis	☐ Left ☐ Right
☐ Instability	☐ Left ☐ Right

☐ Other (please specify) ☐ Left ☐ Right

D. Hips

☐ Contracture ☐ Left ☐ Right
☐ Bony or fibrous ankylosis ☐ Left ☐ Right
☐ Instability ☐ Left ☐ Right
☐ Other (please specify) ☐ Left ☐ Right

E. Knees

☐ Contracture ☐ Left ☐ Right
☐ Bony or fibrous ankylosis ☐ Left ☐ Right
☐ Instability ☐ Left ☐ Right
☐ Other (please specify) ☐ Left ☐ Right

F. Ankles

☐ Contracture ☐ Left ☐ Right
☐ Bony or fibrous ankylosis ☐ Left ☐ Right
☐ Instability ☐ Left ☐ Right
☐ Other (please specify) ☐ Left ☐ Right

G. Are there imaging studies for involved joints?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please provide the following information.

1. Joint involved: _____

☐ Left ☐ Right

Imaging used	Imaging abnormalities
☐ Plain x-ray	☐ Joint space narrowing (state % narrowing _____)
☐ CT	☐ Bony ankylosis ☐ Fibrous ankylosis
☐ MRI	☐ Bone destruction
	☐ Other (describe below)

2. Joint involved: _____

☐ Left ☐ Right

Imaging used	Imaging abnormalities
☐ Plain x-ray	☐ Joint space narrowing (state % narrowing _____)
☐ CT	☐ Bony ankylosis ☐ Fibrous ankylosis
☐ MRI	☐ Bone destruction
	☐ Other (describe below)

3. Joint involved: _____

☐ Left ☐ Right

Imaging used	Imaging abnormalities
☐ Plain x-ray	☐ Joint space narrowing (state % narrowing _____)
☐ CT	☐ Bony ankylosis ☐ Fibrous ankylosis
☐ MRI	☐ Bone destruction
	☐ Other (describe below)

V. The patient's current limitations and capacities

Note 1: The limiting effects of pain or other symptoms should be included in assessment of functional loss.

Note 2: If the patient uses any type of orthotic or prosthetic device, questions pertain to function while using such devices.

A. Lower extremity function (adults and children)

1. Can the patient ambulate without the use of a hand-held assistive device that limits the functioning of both upper extremities?

☐ **Yes** ☐ **No** ☐ **Unknown**

2. Can the patient sustain a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living?

☐ **Yes** ☐ **No** ☐ **Unknown**

For example:

Does the patient have the ability to travel without companion assistance to and from work or school?

☐ **Yes** ☐ **No** ☐ **Unknown**

Does the patient require bilateral upper limb assistive devices, such as two crutches, two canes, or a walker?

☐ **Yes** ☐ **No** ☐ **Unknown**

Is the patient able to walk one block at a reasonable pace on rough or uneven surfaces?

☐ **Yes** ☐ **No** ☐ **Unknown**

Is the patient able to use standard public transportation?

☐ **Yes** ☐ **No** ☐ **Unknown**

Is the patient able to carry out routine ambulatory activities, such as shopping and banking?

☐ **Yes** ☐ **No** ☐ **Unknown**

Is the patient able to climb a few steps at a reasonable pace using a single handrail?

☐ **Yes** ☐ **No** ☐ **Unknown**

Other marked limitation (please specify)

B. Upper extremity function (adults and children)

Does the patient have an extreme loss of function in both upper extremities, to the extent that the ability to perform fine and gross movements seriously interferes with the ability to independently initiate, sustain, or complete activities?

☐ **Yes** ☐ **No** ☐ **Unknown**

For example:

Is the patient able to prepare a meal and feed himself or herself?

☐ **Yes** ☐ **No** ☐ **Unknown**

Is the patient able to take care of personal hygiene?

☐ **Yes** ☐ **No** ☐ **Unknown**

Is the patient able to sort and handle papers or files?

☐ **Yes** ☐ **No** ☐ **Unknown**

Is the patient able to place files in a file cabinet at or above waist level?

☐ **Yes** ☐ **No** ☐ **Unknown**

Other marked limitation (please specify)

C. Specific residual functional capacities and limitations (work-related functions for adults only)

Note: The following questions apply only to patients at least 18 years of age. For children, please see **Section VI**.

1. Does the patient have the ability to stand and/or walk 6 – 8 hours daily on a long-term basis?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **No**, how long can the patient stand and/or walk (with normal breaks) in a 6 – 8 hour work day?

2. What maximum weight can the patient lift and/or carry occasionally (cumulatively not continuously)?

☐ **Unknown**

- ☐ Less than 10 lbs.
- ☐ 10 lbs.
- ☐ 20 lbs.
- ☐ 50 lbs.
- ☐ 100 lbs.
- ☐ Other (lbs.)

3. What weight can the patient lift and/or carry frequently (cumulatively not continuously)?

☐ **Unknown**

- ☐ Less than 10 lbs.
- ☐ 10 lbs.
- ☐ 20 lbs.
- ☐ 50 lbs. or more
- ☐ Other (lbs.)

4. Work environment temperature restrictions

Would the patient's exertional capacities for lifting and carrying (as described in 2 and 3 above) be further reduced by work in extremely hot or cold environments?

☐ **Yes** ☐ **No** ☐ **Unknown**

5. Specific types of function

a. Can the following activities be performed?

Pushing or pulling:
Right arm: ☐ never ☐ occasionally ☐ frequently ☐ unknown
Left arm: ☐ never ☐ occasionally ☐ frequently ☐ unknown

Climbing:
Smooth inclines: ☐ never ☐ occasionally ☐ frequently ☐ unknown
Rough inclines: ☐ never ☐ occasionally ☐ frequently ☐ unknown
Ladders: ☐ never ☐ occasionally ☐ frequently ☐ unknown
Poles: ☐ never ☐ occasionally ☐ frequently ☐ unknown
Stairs: ☐ never ☐ occasionally ☐ frequently ☐ unknown

Overhead work:
Right arm: ☐ never ☐ occasionally ☐ frequently ☐ unknown
Left arm: ☐ never ☐ occasionally ☐ frequently ☐ unknown

Hand controls:
Right arm: ☐ never ☐ occasionally ☐ frequently ☐ unknown
Left arm: ☐ never ☐ occasionally ☐ frequently ☐ unknown

Leg controls: (repetitive force must be applied with leg)
Right arm: ☐ never ☐ occasionally ☐ frequently ☐ unknown
Left arm: ☐ never ☐ occasionally ☐ frequently ☐ unknown

Squatting: ☐ never ☐ occasionally ☐ frequently ☐ unknown

Kneeling: ☐ never ☐ occasionally ☐ frequently ☐ unknown

Crawling: ☐ never ☐ occasionally ☐ frequently ☐ unknown

Crouching: ☐ never ☐ occasionally ☐ frequently ☐ unknown

6. Does the claimant have impairment in balance as a result of lower extremity disease, injury, or reconstructive surgery?

☐ **Yes** ☐ **No** ☐ **Unknown**

7. Fine manipulatory ability

Does the patient have limitations in the ability to perform fine manipulations (precise, coordinated, reasonably rapid use of the fingers)?

☐ **Yes** ☐ **No** ☐ **Unknown**

If Yes, please answer the following questions.

a. Can the patient perform finger-thumb apposition at a normal speed?

☐ **Yes** ☐ **No** ☐ **Unknown**

b. In regard to hand function, could the patient perform the following activities at normal pace?

Handle coins, including picking up coins from a flat surface?
Right hand: ☐ Yes ☐ No ☐ Unknown
Left hand: ☐ Yes ☐ No ☐ Unknown

Handle small parts, as in electronic assembly?
Right hand: ☐ Yes ☐ No ☐ Unknown
Left hand: ☐ Yes ☐ No ☐ Unknown

Use a screwdriver, including positioning small screws in holes?
Right hand: ☐ Yes ☐ No ☐ Unknown
Left hand: ☐ Yes ☐ No ☐ Unknown

Manipulate cloth and sewing thread?

☐ **Yes** ☐ **No** ☐ **Unknown**

VI. For children under age 18 only.

Note: The limiting effects of pain or other symptoms should be included in assessment of functional loss.

Are the child's limitations described in **Section V,** A and B above abnormal for the child's age?

☐ **Yes** ☐ **No** ☐ **Unknown**

If you have other information regarding limitations in age-appropriate abilities, including developmental or other types of testing, please attach copies or discuss the results here.

VII. Additional Physician Comments

Physician's Name (print or type)

Physician's Signature (no name stamps)

Date