CERVICAL SPINE 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. Diagnoses: _____

3. Prognosis: _____

4. Does your patient have chronic pain/paresthesia? ☐ Yes ☐ No

   a. If yes, describe the nature, location, frequency, precipitating factors, and severity of your patient's pain/paresthesia:

   _____

   _____

   b. Does your patient have neuro-anotomic distribution of pain?
   ☐ Yes ☐ No

   c. Identify signs, findings, and associated symptoms of your patient's impairments:

☐ Tenderness	☐ Weight change	☐ Reflex loss
☐ Crepitus	☐ Sensory loss	☐ Swelling
☐ Muscle spasm	☐ Impaired sleep	☐ Atrophy
☐ Muscle weakness	☐ Impaired appetite	☐ Motor loss
☐ Chronic fatigue	☐ Lack of coordination	☐ Drops things
☐ Spastic gait	☐ Abnormal posture	☐ Reduced grip strength

   ☐ other: _____

   d. Does your patient have limitation of motion?
   ☐ Yes ☐ No

   If yes, please indicate cervical range of motion (ROM):

Extension	_____%	Flexion	_____%
Left rotation	_____%	Right rotation	_____%
Left lateral bending	_____%	Right lateral bending	_____%

5. Does your patient have severe headache pain associated with impairment of the cervical spine? ☐ Yes ☐ No

If yes:

a. Please characterize the nature, location and intensity/severity (mild to severe) of your patient's headaches:

_____

_____

_____

b. Identify any other symptoms associated with your patient's headaches:

☐ Vertigo	☐ Weight change	☐ Visual disturbances
☐ Nausea/vomiting	☐ Inability to concentrate	☐ Mood changes
☐ Malaise	☐ Impaired sleep	☐ Mental confusion
☐ Photosensitivity	☐ Exhaustion	☐ Impaired appetite

☐ Other:_____

_____

c. What is the approximate frequency of headaches? _____per week/ ____ per month

d. What is the approximate duration of a typical headache? _ minutes/ ____ hours

e.. What makes your patient's headaches better?

☐ Lie down	☐ Quiet place	☐ Hot pack
☐ Take medication	☐ Dark room	☐ Cold pack

☐ Other_____

6. Identify any other clinical findings and objective signs not mentioned above:

_____

_____

7. Describe the treatment and response including any side effects of medication that may have implications for working, e.g., drowsiness, dizziness, nausea, etc:

_____

_____

8. Have your patient's impairments lasted or can they be expected to last at least twelve months? ☐ Yes ☐ No

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

10. Identify any psychological conditions affecting your patient's physical condition:

☐ Depression	☐ Anxiety
☐ Somatoform disorder	☐ Personality disorder
☐ Psychological factors affecting physical condition	☐ Other: _____

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

If yes, how ***often*** must your patient walk? 1 5 10 15 20 30 45 60 90 (Minutes)

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. 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 have to
☐ lie down,
☐ rest head on a high back chair,
☐ other – describe: _____

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

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.

i. 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.	☐	☐	☐	☐

j. 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	☐	☐	☐	☐

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

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

l. Does your patient have significant limitations with reaching, handling or fingering?
☐ Yes ☐ No

If yes, 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:	**%**	**%**	**%**	**%**

m. 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

n. 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

Please explain the reasons for your conclusion: _____

o. 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 describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

_____

_____

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____

_____