SOMATOFORM IMPAIRMENT QUESTIONNAIRE (RFC & LISTINGS)

From: _____

Re: _____ (Name of Patient)

_____ (Social Security No.)

Please answer the following questions concerning your patient's impairments. *Attach all relevant treatment notes, laboratory and test results as appropriate.*

1. Frequency and length of contact: _____

2. DSM-IV Multiaxial Evaluation:

   Axis I: _____ Axis IV: _____

   Axis II: _____ Axis V: Current GAF: _____

   Axis III: _____ Highest GAF Past year: _____

3. **If your patient has a Somatoform diagnosis**, identify the signs and symptoms:

	History of pain; identify sites		Menstrual irregularities
	Site:		History of sexual difficulties
	Site:		Urinary complaints
	Site:		History of neurologic symptoms or conversion:
	Site:		Site:
	Site:		Site:
	Site:		Site:
	Gastrointestinal:		Gait or arm problems
	Loss of appetite		Sleep disturbances
	Nausea, vomiting		Associated depression
	Bloating, gas		Associated anxiety
	Abdominal pain		Preoccupation with own health condition(s)
	Other (specify)		Vision, speech or hearing disturbance
	Chronic fatigue		Disturbance in movement, control or sensation
	Weakness		Preoccupation or belief there is a serious illness
	Heartbeat irregularities (racing, pounding)		Other symptoms: *(specify)*

a. Have these symptoms caused your patient to take medicine frequently, see a physician often and alter life patterns significantly? ☐ Yes ☐ No

   If yes, please explain:

b. Can these symptoms be *better* explained by a Mood, Psychotic, Substance or Anxiety Disorder? ☐ Yes ☐ No

c. Is there an absence of objective findings and lab results to explain the symptoms? ☐ Yes ☐ No

d. Does your patient have an unrealistic interpretation of physical signs or sensations associated with the preoccupation or belief that he or she has a serious disease? ☐ Yes ☐ No

4. Identify signs and symptoms associated with **all other DSM-IV diagnoses**:

	Poor memory		Oddities of thought, perception, speech or behavior
	Appetite disturbance with weight change		Perceptual disturbances
	Sleep disturbance		Time or place disorientation
	Personality change		Catatonia or grossly disorganized behavior
	Mood disturbance		Social withdrawal or isolation
	Emotional lability		Blunt, flat or inappropriate affect
	Loss of intellectual ability of 15 IQ points or more		Illogical thinking or loosening of associations
	Delusions or hallucinations		Decreased energy and general inactivity
	Substance dependence		Manic syndrome
	Recurrent panic attacks		Obsessions or compulsions
	Anhedonia or pervasive loss of interests		Intrusive recollections of a traumatic experience
	Psychomotor agitation or retardation		Persistent irrational fears
	Paranoia or inappropriate suspiciousness		Generalized persistent anxiety
	Feelings of guilt/worthlessness		Hostility and irritability
	Difficulty thinking or concentrating		Pathological dependence or passivity
	Suicidal ideation or attempts		Relational/family problems
	Inability for selfcare activities		Other:
	Contact with law enforcement		

5. Describe the *clinical findings* (onset, duration and results of mental status exam) that demonstrate the severity of your patient's mental impairment and symptoms:

6. Treatment and response:

7. a. List of prescribed medications and dosage

b. Describe any side effects of medications that may have implications for working. E.g., dizziness, drowsiness, fatigue, lethargy, stomach upset, etc.:

8. Prognosis: _____

9. Has your patient's impairment lasted or can it be expected to last at least twelve months?
☐ Yes ☐ No

10. Does the psychiatric condition exacerbate your patient's experience of pain or any other physical symptom? ☐ Yes ☐ No

If yes, please explain:

11. If your patient has a low I.Q. or reduced intellectual functioning, please explain with reference to specific test results:

12. 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

13. To determine your patient's ability to do *work-related activities on a day-to-day basis in a regular work setting,* please give us your opinion **based on your examination** of how your patient's mental/emotional capabilities are affected by the impairment(s). Consider the medical history, the chronicity of findings (or lack thereof), and the expected duration of any work-related limitations, but not your patient's age, sex or work experience.

- *Limited but satisfactory* means your patient has noticeable difficulty (e.g., distracted from job activity) no more than 10 percent of the workday or work week.
- *Seriously limited* means your patient has noticeable difficulty (e.g., distracted from job activity) from 11 to 20 percent of the workday or work week.
- *Unable to meet competitive standards* means your patient has noticeable difficulty (e.g., distracted from job activity) from 21 to 40 percent of the workday or work week.
- *No useful ability to function*, an extreme limitation, means your patient cannot perform this activity on a regular, reliable and sustained schedule in a regular work setting.

I.	MENTAL ABILITIES AND APTITUDES NEEDED TO DO UNSKILLED WORK	Unlimited or Very Good	Limited but satisfactory	**Seriously limited**	**Unable to meet competitive standards**	**No useful ability to function**
A.	Remember work-like procedures					
B.	Understand and remember very short and simple instructions					
C.	Carry out very short and simple instructions					
D.	Maintain attention for two hour segment					
E.	Maintain regular attendance and be punctual within customary, usually strict tolerances					
F.	Sustain an ordinary routine without special supervision					
G.	Work in coordination with or proximity to others without being unduly distracted					
H.	Make simple work-related decisions					
I.	Complete a normal workday and workweek without interruptions from psychologically based symptoms					
J.	Perform at a consistent pace without an unreasonable number and length of rest periods					
K.	Ask simple questions or request assistance					
L.	Accept instructions and respond appropriately to criticism from supervisors					
M.	Get along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes					
N.	Respond appropriately to changes in a routine work setting					
O.	Deal with normal work stress					
P.	Be aware of normal hazards and take appropriate precautions					

(Q) Explain limitations falling in the three most limited categories (identified by **bold type)** and include the medical/clinical findings that support this assessment:

II.	MENTAL ABILITIES AND APTITUDES NEEDED TO DO SEMISKILLED AND SKILLED WORK	Unlimited or Very Good	Limited but satisfactory	**Seriously limited**	**Unable to meet competitive standards**	**No useful ability to function**
A.	Understand and remember detailed instructions					
B.	Carry out detailed instructions					
C.	Set realistic goals or make plans independently of others					
D.	Deal with stress of semiskilled and skilled work					

(E) Explain limitations falling in the three most limited categories (identified by **bold type)** and include the medical/clinical findings that support this assessment:

III.	MENTAL ABILITIES AND APTITUDE NEEDED TO DO PARTICULAR TYPES OF JOBS	Unlimited or Very Good	Limited but satisfactory	**Seriously limited**	**Unable to meet competitive standards**	**No useful ability to function**
A.	Interact appropriately with the general public					
B.	Maintain socially appropriate behavior					
C.	Adhere to basic standards of neatness and cleanliness					
D.	Travel in unfamiliar place					
E.	Use public transportation					

(F) Explain limitations falling in the three most limited categories (identified by **bold type)** and include the medical/clinical findings that support this assessment:

14. Indicate to what degree the following functional limitations exist as a result of your patient's mental impairments. *Note*: **Marked** means more than moderate but less than extreme. A marked limitation my arise when several activities or functions are impaired or even when only one is impaired, so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, effectively, and on a sustained basis.

FUNCTIONAL LIMITATION					
A.	Restriction of activities of daily living	None-Mild ☐	Moderate ☐	Marked ☐	Extreme ☐
B.	Difficulties in maintaining social functioning	None Mild ☐	Moderate ☐	Marked ☐	Extreme ☐
C.	Difficulties in maintaining concentration, persistence or pace	None Mild ☐	Moderate ☐	Marked ☐	Extreme ☐
D.	Episodes of decompensation* within 12 month period, each of at least two weeks duration**	None ☐	One or Two ☐	Three ☐	Four or More ☐

* Episodes of decompensation are exacerbations or temporary increases in symptoms or signs accompanied by a loss of adaptive functioning, as manifested by difficulties in performing activities of daily living, maintaining social relationships, or maintaining concentration, persistence or pace. Episodes of decompensation may be demonstrated by an exacerbation of symptoms or signs that would ordinarily require increased treatment or a less stressful situation (or a combination of the two).

** If within one year your patient had more than three episodes of decompensation of shorter duration than two weeks or less frequent episodes of decompensation of longer duration than two weeks, please give the dates of each episode of decompensation:

_____

_____

15. Please indicate if any of the following apply to your patient:

☐ Medically documented history of a chronic organic mental, schizophrenic, etc. or affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do any basic work activity, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:

1. ☐ Three episodes of decompensation within 12 months, each at least two weeks long.

2. ☐ A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate.

3. ☐ Current history of 1 or more years' inability to function outside a highly supportive living arrangement with an indication of continued need for such an arrangement.

☐ **Complete** inability to function independently outside the area of one's home.

16. Please describe your patient's ability to perform the following activities at a regular job on a sustained (8 hours per day, 5 days a week) basis:

a. Maximum ability to lift and carry on an *occasional* basis (no more than 1/3 of an 8-hour day).

☐ No limitation ☐ 100# ☐ 50# ☐ 20# ☐ 10# ☐ less than 10#

b. Maximum ability to lift and carry on a *frequent* basis (1/3 to 2/3 of an 8-hour day).

☐ No limitation ☐ 50# ☐ 25# ☐ 10# ☐ less than 10#

c. Maximum ability to stand and walk (with normal breaks) during an 8-hour day.

☐ No limitation ☐ about 6 hours ☐ about 4 hours ☐ about 3 hours
☐ about 2 hours ☐ less than 2 hours

d. Maximum ability to sit (with normal breaks) during an 8-hour day.

☐ No limitation ☐ about 6 hours ☐ about 4 hours ☐ about 3 hours
☐ about 2 hours ☐ less than 2 hours

17. Must your patient periodically alternate sitting, standing, or walking to relieve discomfort ? ☐ Yes ☐ No

If yes, please answer the following:

a) How long can your patient ***sit*** before changing position? 0 5 10 15 20 30 45 60 90
Minutes

b) How long can your patient ***stand*** before changing position? 0 5 10 15 20 30 45 60 90 Minutes

c) How often must your patient ***walk around***? Frequency: 0 5 10 15 20 30 45 60 90 Minutes

d) How long must your patient ***walk each time***? Duration: 0 5 10 15 20 30 45 60 90 Minutes

e) Does your patient need the opportunity to shift ***at will*** from sitting or standing/walking? ☐ Yes ☐ No

18. Will your patient sometimes need to lie down at unpredictable intervals during a work shift? ☐ Yes ☐ No

If yes, please answer the following:

a) How often do you think this will happen? _____

b) How long will your patient need to be away from the work station each time? _____

19. Are your patient's impairments *reasonably consistent* with the symptoms and functional limitations described in this evaluation? ☐ Yes ☐ No

If no, please explain: _____

20. Please describe any other limitations (such as limitations in doing repetitive reaching, handling or fingering, 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.

21. Can your patient manage benefits in his or her own best interest? ☐ Yes ☐ No

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____

_____

248-1
9/10
7-77