MENTAL IMPAIRMENT QUESTIONNAIRE (RFC & LISTINGS)

To: _____

Re: _____(Name of Patient)

_____(Social Security No.)

Please answer the following questions concerning your patient's impairments. *Attach all relevant treatment notes and test results which have not been provided previously to the Social Security Administration.*

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. Identify your patient's signs and symptoms:

	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

	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		Somatization unexplained by organic disturbance
	Difficulty thinking or concentrating		Hostility and irritability
	Suicidal ideation or attempts		Pathological dependence or passivity

Other symptoms and remarks:

_____

_____

_____

4. Describe the *clinical findings* including results of mental status examination which demonstrate the severity of your patient's mental impairment and symptoms:

_____

_____

_____

5. Is your patient a malingerer?

Yes No

6. Are your patient's impairments reasonably consistent with the symptoms and functional limitations described in this evaluation?

Yes No

If no, please explain:

_____

7. Treatment and response:

_____

_____

8. a. List of prescribed medications:

NAME OF MEDICATION AND DOSAGE	DAILY AMOUNT TAKEN

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

_____

_____

9. Prognosis:

_____

_____

10. Has your patient's impairment lasted or can it be expected to last at least twelve months?

Yes No

11. Does the psychiatric condition exacerbate your patient's experience of pain or any other physical symptom?

Yes No

If yes, please explain:

_____

_____

12. Does your patient have a low I.Q. or reduced intellectual functioning?

Yes No

Please explain (with reference to specific test results):

_____

_____

13. On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?

___ Never ___ About once a month ___ About three times a month
___ Less than once a month ___ About twice a month ___ More than three times a month

14. 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 the individual's age, sex or work experience.

For each activity shown below:

a. *Describe your patient's ability to perform the activity according to the following terms:*

Unlimited or Very Good:	Ability to function in this area is more than satisfactory.
Good:	Ability to function in this area is limited but satisfactory.
Fair:	Ability to function in this area is seriously limited, but not precluded.
Poor or None:	No useful ability to function in this area.

b. *Identify the particular medical or clinical findings (e.g., mental status examination, behavior, intelligence test results, symptoms) which support your opinion regarding any limitations.*

IT IS IMPORTANT THAT YOU RELATE PARTICULAR MEDICAL FINDINGS TO ANY REDUCTION IN CAPACITY; THE USEFULNESS OF YOUR OPINION DEPENDS ON THE EXTENT TO WHICH YOU DO THIS.

I.	**MENTAL ABILITIES AND APTITUDE NEEDED TO DO UNSKILLED WORK**	**Unlimited or Very Good**	**Good**	**Fair**	**Poor or None**
(1)					
(2)					
(3)					
(4)					
(5)					

(6)	Remember work-like procedures				
(7)	Understand and remember very short and simple instructions				
(8)	Carry out very short and simple instructions				
(9)	Maintain attention for two hour segment				
(10)	Maintain regular attendance and be punctual within customary, usually strict tolerances				
(11)	Ask simple questions or request assistance				
(12)	Accept instructions and respond appropriately to criticism from supervisors				
(13)	Get along with co-workers or peers without unduly distracting them or exhibiting behavioral extremes				
(14)	Respond appropriately to changes in a routine work setting				
(15)	Deal with normal work stress				
(16)	Be aware of normal hazards and take appropriate precautions				

(17) Explain limitations falling into the fair and poor categories and identify the medical/clinical findings that support this assessment:

_____

_____

_____

II.	**MENTAL ABILITIES AND APTITUDES NEEDED TO DO SEMISKILLED AND SKILLED WORK**	**Unlimited or Very Good**	**Good**	**Fair**	**Poor or None**
(1)	Understand and remember detailed instructions				
(2)	Carry out detailed instructions				
(3)	Set realistic goals or make plans independently of others				
(4)	Deal with stress of semiskilled and skilled work				

(5) Explain limitations falling into the fair and poor categories and identify the medical/clinical findings that support this assessment:

_____

_____

III.	MENTAL ABILITIES AND APTITUDES NEEDED TO DO PARTICULAR TYPES OF JOBS	Unlimited or Very Good	Good	Fair	Poor or None
(1)	Interact appropriately with the general public				
(2)	Maintain socially appropriate behavior				
(3)	Adhere to basic standards of neatness and cleanliness				
(4)	Travel in unfamiliar place				
(5)	Use public transportation				

(6) Explain limitations falling into the fair and poor categories and identify the medical/clinical findings that support this assessment:

_____

_____

15. Indicate to what degree the following functional limitations exist as a result of your patient's mental impairments.

FUNCTIONAL LIMITATION		DEGREE OF LIMITATION				
(1)	Restriction of activities of daily living	None	Mild	Moderate	Marked*	Extreme
(2)	Difficulties in maintaining social functioning	None	Mild	Moderate	Marked*	Extreme
(3)	Deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (in work settings or elsewhere)	None	Mild	Moderate	Marked*	Extreme
(4)	Episodes of deterioration or decompensation in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors)	Never	Once or Twice	Three	Repeated (four or more)	Continual

**Note:* Marked means more than moderate, but less than extreme. A marked limitation may 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 and effectively.

16. Please describe any other limitations (such as limitations in the ability to sit, stand, walk, lift, bend, stoop, limitations using arms, hands, fingers, 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:

_____

_____

_____

17. Can your patient manage benefits in his or her own best interest?

Yes No

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____

_____

Co-Signature

_____

Print Name

_____

Telephone