Form Approved
OMB No.0960-0662

MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES (PHYSICAL)

NAME OF INDIVIDUAL **SOCIAL SECURITY NUMBER**

To determine this individual's ability to do **work-related activities on a regular and continuous basis**, please give us your opinion for each activity shown below:

The following terms are defined as:

- **REGULAR AND CONTINUOUS BASIS** means 8 hours a day, for 5 days a week, or an equivalent work schedule.
- **OCCASIONALLY** means very little to one-third of the time.
- **FREQUENTLY** means from one-third to two-thirds of the time.
- **CONTINUOUSLY** means more than two-thirds of the time.

Age and body habitus of the individual should not be considered in the assessment of limitations. It is important that you relate particular medical or clinical findings to any assessed limitations in capacity: The usefulness of your assessment depends on the extent to which you do this.

I. LIFTING/CARRYING

Check the boxes representing the amount the individual can lift and how often it can be lifted.

Lift	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
A. Up to 10 lbs:				
B. 11 to 20 lbs:				
C. 21 to 50 lbs:				
D. 51 to 100 lbs:				

Check the boxes representing the amount the individual can carry and how often it can be carried.

Carry	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
A. Up to 10 lbs:				
B. 11 to 20 lbs:				
C. 21 to 50 lbs:				
D. 51 to 100 lbs:				

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

II. SITTING/STANDING/WALKING

Please check how many hours the individual can (if less than one hour, how many minutes):

At One Time without Interruption

	Minutes	Hours							
A. Sit	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
B. Stand	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
C. Walk	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

Total in an 8 hour work day

	Minutes	Hours							
A. Sit	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
B. Stand	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8
C. Walk	_____	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8

If the total time for sitting, standing and walking does not equal or exceed 8 hours, what activity is the individual performing for the rest of the 8 hours?

Does the individual require the use of a cane to ambulate? ☐ Yes ☐ No

If the answer is "yes" please answer the following:

- How far can the individual ambulate without the use of a cane? _____
- Is the use of a cane medically necessary? ☐ Yes ☐ No
- Without a cane, can the individual use his/her free hand to carry small objects? ☐ Yes ☐ No

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

III. USE OF HANDS

Indicate how often the individual can perform the following activities:

ACTIVITY	Right Hand					Left Hand			
	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)		Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
REACHING (Overhead)									
REACHING (All Other)									
HANDLING									
FINGERING									
FEELING									
PUSH/PULL									

Which is the individual's dominant hand? ☐ Right Hand ☐ Left Hand

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

IV. USE OF FEET

Indicate how often the individual can perform the following activities:

ACTIVITY	Right Foot					Left Foot			
	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)		Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
Operation of Foot Controls									

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

V. POSTURAL ACTIVITIES

How often can the individual perform the following activities?

ACTIVITY	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
Climb stairs and ramps				
Climb ladders or scaffolds				
Balance				
Stoop				
Kneel				
Crouch				
Crawl				

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

VI. DO ANY OF THE IMPAIRMENTS AFFECT THE CLAIMANT'S HEARING OR VISION?

☐ No ☐ Yes ☐ Not Evaluated

If "yes" please complete the following questions (where appropriate)

1. If a **hearing impairment** is present,

   a. Does the individual retain the ability to hear and understand simple oral instructions and to communicate simple information? ☐ Yes ☐ No

   b. Can the individual use a telephone to communicate? ☐ Yes ☐ No

2. If a **visual impairment** is present,

   a. Is the individual able to avoid ordinary hazards in the workplace, such as boxes on the floor, doors ajar, or approaching people or vehicles? ☐ Yes ☐ No

   b. Is the individual able to read very small print? ☐ Yes ☐ No

   c. Is the individual able to read ordinary newspaper or book print? ☐ Yes ☐ No

   d. Is the individual able to view a computer screen? ☐ Yes ☐ No

   e. Is the individual able to determine differences in shape and color of small objects such as screws, nuts or bolts? ☐ Yes ☐ No

      Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

VII. ENVIRONMENTAL LIMITATIONS

How often can the individual tolerate exposure to the following conditions?

Condition	Never	Occasionally (up to 1/3)	Frequently (1/3 to 2/3)	Continuously (over 2/3)
Unprotected Heights				
Moving Mechanical Parts				
Operating a motor vehicle				
Humidity and wetness				
Dust, odors, fumes and pulmonary irritants				
Extreme cold				
Extreme heat				
Vibrations				
Others: (Identify)				

Condition	Quiet (Library)	Moderate (Office)	Loud (Heavy Traffic)	Very Loud (Jackhammer)
Noise				

Identify the particular medical or clinical findings (i.e., physical exam findings, x-ray findings, laboratory test results, history, and symptoms including pain etc.) which support your assessment or any limitations and why the findings support the assessment.

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VIII. PLEASE PLACE A CHECK IN APPROPRIATE BOXES BASED SOLELY ON THE CLAIMANT'S PHYSICAL IMPAIRMENTS

ACTIVITY	YES	No
Can the individual perform activities like shopping?		
Can the individual travel without a companion for assistance?		
Can the individual ambulate without using a wheelchair, walker, or 2 canes or 2 crutches?		
Can the individual walk a block at a reasonable pace on rough or uneven surfaces?		
Can the individual use standard public transportation?		
Can the individual climb a few steps at a reasonable pace with the use of a single hand rail?		
Can the individual prepare a simple meal & feed himself/herself?		
Can the individual care for personal hygiene?		
Can the individual sort, handle, use paper/files?		

Please identify the medical findings that support this assessment and why the finding support the assessment (unless a narrative report is attached).

IX. STATE ANY OTHER WORK-RELATED ACTIVITIES, WHICH ARE AFFECTED BY ANY IMPAIRMENTS, AND INDICATE HOW THE ACTIVITIES ARE AFFECTED. WHAT ARE THE MEDICAL FINDINGS THAT SUPPORT THIS ASSESSMENT?

X. THE LIMITATIONS ABOVE ARE ASSUMED TO BE YOUR OPINION REGARDING CURRENT LIMITATIONS ONLY.

HOWEVER, IF YOUR HAVE SUFFICIENT INFORMATION TO FORM AN OPINION WITHIN A REASONABLE DEGREE OF MEDICAL PROBABILITY AS TO PAST LIMITATIONS, ON WHAT DATE WERE THE LIMITATIONS YOU FOUND ABOVE FIRST PRESENT? _____

XI. HAVE THE LIMITATIONS YOU FOUND ABOVE LASTED OR WILL THEY LAST FOR 12 CONSECUTIVE MONTHS? ☐ **Yes** ☐ **No**

_____ _____

SIGNATURE DATE

_____

Print Name, Title and Medical Specialty (Legibly Please)

PRIVACY ACT STATEMENT:

The Social Security Administration is authorized to collect the information on this form under sections 205(a), 223(d), 1614(a)(3)(H)(I) and 1631(d)(1) of the Social Security Act. The information on this form is needed by Social Security to complete processing of the named patient's claim. While giving us the information on this form is voluntary, failure to provide the requested information may prevent an accurate or timely decision on the named patient's claim. Although the information you furnish on this form is almost never used for any purpose other than making a determination about disability, such information may be disclosed by the Social Security Administration to another person or governmental agency only with respect to Social Security programs and to comply with federal laws requiring the exchange information between Social Security and another agency.

Explanations about these and other reasons why information about you may be used or given out are available in Social Security offices. If you want to learn more about this, contact any Social Security office.

PAPERWORK REDUCTION ACT:

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