FIBROMYALGIA SYNDROME
MEDICAL ASSESSMENT FORM

TO: Dr.. _____

RE: _____

SSN: _____

Please answer the following questions concerning your patient's fibromyalgia and other impairments.

1. Date began treatment: _____ Frequency of Tx: _____

2. Does your patient meet the 1990 diagnostic criteria for **fibromyalgia** syndrome identified by the American College of Rheumatology including the presence of multiple tender points?
___ Yes ___ No

Does your patient exhibit **chronic fatigue syndrome**? ___ Yes ___ No

Other diagnoses: _____

3. Prognosis: _____

4. Identify all of your patient's **symptoms**:

____ chronic pain
____ non-restorative sleep
____ muscle weakness
____ breathlessness
____ morning stiffness
____ subjective swelling
____ multiple chemical sensitivities
____ frequent, severe headaches
____ female urethral syndrome
____ premenstrual syndrome (PMS)
____ vestibular dysfunction
____ temporomandibular joint dysfunction (TMJ)
____ numbness and tingling/parasthesia
____ sicca symptoms
____ chronic fatigue
____ Raynaud's phenomenon
____ dysmenorrhea
____ anxiety/panic attacks
____ irritable bowel syndrome
____ depression
____ mitral valve prolapsed
____ hypothyroidism
____ carpal tunnel syndrome
____ other: _____

A. If your patient exhibits chronic **pain/parasthesia**, characterize the **severity** of the pain/parasthesia: ____ mild ____ moderate____ severe

B. Identify the location and frequency of **pain/parasthesia** by shading the relevant body portions and labeling as constant (C), frequent (F), or intermittent (I):

C. Identify any positive objective signs of your patient's impairment(s):

____ SLR left at ____%	____ tenderness	____weight change
right at ____%	____ crepitus	____ joint warmth
____ sensory changes	____ joint changing	____ reflex changes
____ spasm	____ impaired sleep	____ atrophy
____ muscle weakness	____ impaired appetite	____motor loss
____ abnormal gait	____ limitation of motion	____ joint instability
____ chronic fatigue	____ joint deformity	____ reduced grip strength

____ other: _____

5. Identify any other positive clinical findings and test results (e.g., myelogram, MRI, CT scans, EMG/NCS):
_____

For this and other questions on this form, "rarely" means 1% to 5% of an eight-hour working day; "occasionally" means 6% to 33% of an eight-hour working day; "frequently" means 34% to 66% of an eight-hour working day.

6. If your patient experiences symptoms which interfere with the **attention and concentration** needed to perform even simple tasks, during a typical workday, please estimate the **frequency** of interference:
____ rarely ____ occasionally ____ at least frequently

7. If your patient was placed in a competitive job, identify those aspects of **workplace stress** that you patient would be **unable to perform** or be exposed to:

____ public contact
____ routine, repetitive tasks at consistent pace
____ detailed or complicated tasks
____ strict deadlines
____ close interaction with coworkers/supervisors
____ fast paced tasks (e.g., production line)
____ exposure to work hazards (e.g., heights or moving machinery)
____ other: _____

8. Identify any **side effects** of any medications which may have implications for working:

____ drowsiness/sedation ____ other: _____

9. Have your patient's impairments lasted or can they be expected to last at least twelve months?

10. As a result of your patient's impairment(s), estimate your patient's functional limitations assuming your patient was placed in a *competitive work situation* on an ongoing basis:

A How many city blocks can the patient **walk** without rest or severe pain?_____

B. Please circle the hours or minutes that your patient can *continuously* sit and stand ***at one time***:

1. **Sit**: 0 5 10 15 20 30 45 1 2, More than 2
Minutes Hours

What must your patient usually do after sitting this long?
____ walk ____ stand ____ lie down ____ other: _____

2. **Stand**: 0 5 10 20 30 45 1 2, More than 2
Minutes Hours

What must your patient do after standing this long?
____ walk ____ sit ____ lie down ____ other: _____

C. Please indicate how long your patient can sit and stand/walk ***total*** *in an eight hour work day* (with normal breaks)?

Sit	**Stand/Walk**	
____	____	less than 2 hours
____	____	about 2 hours
____	____	about 4 hours
____	____	at least 6 hours

D. If your patient's symptom(s) would likely cause the need to take **unscheduled breaks** to rest during an average eight-hour workday,

1) **How many times** during an average workday do you expect this to happen?
0 1 2 3 4 5 6 7 8 9 10, more than 10

2) **How long** (on average) will your patient have to rest before returning to work?
Less than 5, 5 10 20 30 45 1 2, more than 2
Minutes Hours

3) What symptom(s) cause a need for breaks?
____ muscle weakness ____ pain/parasthesia
____ chronic fatigue ____ adverse effects of medication
____ other:_____

E. With prolonged sitting, should your patient's legs be **elevated**?

____ Yes ____ No

If yes, 1) How *high* should the leg(s) be elevated? _____

2) If your patient had a sedentary job, what percentage of time during an eight-hour workday should the legs be elevated? _____%

3) What symptom(s) cause a need to elevate the legs?
____ edema ____pain/parasthesia
____ other: _____

F. While engaging in even occasional standing/walking must your patient use a **cane** or other assistive device for balance? ____ Yes ____ No

G. How many pounds can the patient **lift and carry** in a competitive work situation?

	Never	**Rarely**	**Occasionally**	**Frequently**
Less than 10 lbs.	____	____	____	____
10 lbs.	____	____	____	____
20 lbs.	____	____	____	____
50 lbs.	____	____	____	____

H. How often can your patient perform the following waist-level activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Twist	____	____	____	____
Stoop (bend)	____	____	____	____

I. If your patient has significant limitations with **reaching, handling or fingering**, please estimate the percentage of time during an eight-hour workday that your patient can use hands/fingers/arms for the following activities:

	HANDS: grasp, turn twist objects	**FINGERS: fine manipulations**	**ARMS: reaching (incl. overhead)**
Right	_____%	_____%	_____%
Left	_____%	_____%	_____%

J. Does your patient exhibit sensitivities to certain **environmental conditions?**

____ Yes ____ No

If yes, identify conditions to which your patient must avoid even occasional exposure:

____ latex	____ air conditioning	____ outdoor cold or heat
____ high humidity	____ cigarette smoke	____ cleaners
____ dust	____ perfumes/colognes	____ food odors
____ fumes/gases	____ other:_____	

K. Please estimate, on average, how often your patient is likely to be **absent** from work as a result of impairment(s) and treatment:

____ never/less than once a month	____ about four days a month
____ about once or twice a month	____ more than four days a month
____ about three days a month	

Signed: _____ Date: _____

Print Name: _____

Address: _____

_____

_____

Re: ___ _____ SSN: _____

To determine your patient's ability to do work-related activities on a day-to-day basis in a regular work setting, please give 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.

_ **Seriously limited, but not precluded** means ability to function in this area is seriously limited and less than satisfactory, but not precluded. This is a substantial loss of ability to perform the work-related activity.

_ **Unable to meet competitive standards** means your patient cannot satisfactorily perform this activity independently, appropriately, effectively and on a sustained basis in a regular work setting.

_ **No useful ability to function**, an extreme limitation, means your patient cannot perform this activity in a regular work setting.

Mental Abilities and Aptitude Needed to Work

		Unlimited or Very Good	Limited, but satisfactory	Seriously limited, but not precluded	Unable to meet competitive standards	No useful ability to function
1.	Interact appropriately with general public.	_____	_____	_____	_____	_____
2.	Understand, remember and carry out very short and simple instructions	_____	_____	_____	_____	_____
3.	Maintain attention and and concentration for extended periods.	_____	_____	_____	_____	_____
4.	Complete a normal workday and workweek without interruption from physically and/or psychologically based symptoms.	_____	_____	_____	_____	_____
5.	Perform routine repetitive work at a consistent pace without an unreasonable number and length of rest periods.	_____	_____	_____	_____	_____
6.	Deal with normal work stress.	_____	_____	_____	_____	_____

Signature:_____ Date: _____