HEADACHES
MEDICAL SOURCE STATEMENT

TO: _____

RE: _____

SSN: XXX-XX-

Please answer the following questions concerning your patient's* headaches *if they were working 8 hours a day 5 days a week continuously 52 weeks a year in a competitive work setting.

Attaching any / all relevant treatment notes, laboratory and test results which have not been provided previously to the Social Security Administration provides further information of record.

1. Nature, frequency and length of contact: _____

   _____

2. Diagnoses: _____

   _____

3. Does your patient have headaches? ___ Yes ___ No

   If yes, please **characterize the nature, location and intensity / severity (mild to severe)**

   of your patient's headaches: _____

   _____

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

   ___ Vertigo ___ Malaise ___ Nausea / vomiting
   ___ Mood changes ___ Visual disturbances ___ Photosensitivity
   ___ Mental confusion / inability to concentrate
   ___ Other: _____

5. What is the approximate **frequency** of headaches? _____

6. What is the approximate **duration** of your patient's headaches? _____

7. What **triggers** your patient's headaches?

___ Alcohol ___ Stress ___ Noise ___ Hunger
___ Menstruation ___ Strong odors ___ Bright lights
___ Lack of sleep ___ Vigorous exercise ___ Weather changes
___ Food - identify: _____
___ Other: _____

8. What makes your patient's headaches worse?

___ Noise ___ Bright lights ___ Moving around
___ Coughing, straining / bowel movement

9. What makes your patient's headaches better?

___ Lying in a dark room ___ Cold / hot packs ___ Finger pressure / massage
___ Other: _____

10. Identify any positive test results and objective signs of your patient's headaches:

___ MRI ___ CT scan ___ X-ray
___ EEG ___ Weight loss ___ Tenderness
___ Impaired sleep ___ Impaired appetite or gastritis
___ Other: _____

11. Identify any impairment(s) that could reasonably be expected to explain your patient's headaches:

___ Anxiety / tension ___ Migraine ___ Sinusitis
___ Hypertension ___ Seizure disorder ___ Cerebral hypoxia
___ Cervical disc disease ___ Substance abuse ___ History of head injury
___ Intracranial infection or tumor
___ Other_____

12. To what degree do emotional factors contribute to the severity of your patient's headaches?

___ Not at all ___ Somewhat ___ Very much

13. Are your patient's impairments **(physical impairments plus any emotional impairments)** reasonably **consistent** with the **symptoms and functional limitations described** in this evaluation? ___ Yes ___ No

If no, please explain: _____

14. Describe the **treatment and response**: _____

_____

15. List your patient's **current medications** used for control/treatment of headaches: _____

_____

16. Identify **side effects** of these medications experienced by your patient: _____

_____

17. Prognosis: _____

18. Have the patient's impairments lasted or can they be expected to last at least twelve months? ___ Yes ___ No

19. During times your patient has a headache, would your patient generally be precluded from performing even basic work activities and need a break from the workplace?
___ Yes ___ No
If no, please explain: _____

_____

20. Will your patient sometimes need to take unscheduled breaks during an 8 hour 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 need to lie down or sit quietly? _____

_____

21. To what degree can your patient tolerate work stress?

___ Incapable of even "low stress" jobs
___ Capable of low stress jobs
___ Moderate stress is okay
___ Capable of high stress work

Please explain the reasons for your conclusion: _____

_____

_____

22. Are your patient's impairments likely to produce "good days" and "bad days"

___ Yes ___ No

If yes, will your patient likely to be absent from work 3 or more days per month:

___ Yes ___ No

23. Please describe any other limitations (such as limitations in the ability to sit, stand, walk, lift, bend, stoop, crouch, limitations in 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: _____

_____

_____

24. Identify any additional tests or procedures you would advise to fully assess your patient's impairments, symptoms and limitations: _____

_____

_____

Date: _____ Signature: _____

Printed/Typed Name: _____

Address: _____

_____

_____