

**AFFECTIVE DISORDERS
PROFESSIONAL SOURCE
DATA SHEET**
Short form

FOR REPRESENTATIVE USE ONLY

REPRESENTATIVE'S NAME AND ADDRESS

REPRESENTATIVE'S TELEPHONE

REPRESENTATIVE'S EMAIL

PROFESSIONAL SOURCE NAME AND ADDRESS

PROFESSIONAL SOURCE TELEPHONE

PROFESSIONAL SOURCE EMAIL

PATIENT'S TELEPHONE

PATIENT'S NAME AND ADDRESS

PATIENT'S EMAIL

PATIENT'S SSN

LEVEL OF ADJUDICATION:

Initial DDS Recon DDS

Initial CDR Hearing Officer

Administrative Law Judge Appeals Council

Federal District Court Federal Appeals Court

TYPE OF CLAIM:

Title 2 DIB/DWB CDB

Title 16 DI DC

Dear Dr.

We are pursuing the Social Security disability claim for the above-named individual (the "patient"). We understand how valuable your time is, and this data sheet has been designed to allow you to provide medical information in an efficient and organized way. As a treating physician, your records and medical judgment are vital in arguing for a fair disability determination for the patient before the Social Security Administration (SSA). If you receive multiple data sheets, please disregard repetitive questions.

Your medical or other specialty please:

Note 1: This document may not have legal validity for Social Security disability determination purposes unless completed by a licensed M.D. or D.O., preferably a psychiatrist. A licensed Ph.D.-level clinical psychologist experienced in the evaluation of affective disorders may also complete parts of this form not concerning medical diagnosis of any brain or other physical disorder, medication, physical examination findings, or interpretation of any medical test (including neuroimaging).

Note 2: This document only concerns affective mental disorders. Other impairments and limitations resulting from a combination of impairments should be considered separately.

Note 3: Age, degree of general physical conditioning, sex, body habitus (i.e., natural body build, physique, constitution, size, and weight), insofar as they are unrelated to the patient's medical disorder and symptoms, should not be considered when assessing the functional severity of the impairment.

I. Does the patient have an affective mental disorder?

Yes No

If **Yes**, please specify the diagnosis, or check **Unknown**.

Unknown

II. When did the patient first complain to you of symptoms consistent with an affective mental disorder?

Date:

III. Is the patient currently abusing alcohol or other drugs?

Yes No Unknown

IV. Treatment

(Please include medications and side-effects experienced.)

V. Which of the following clinical abnormalities are persistently present, either continuously or intermittently?

A. Depressive Syndrome

1. Depressed or irritable mood
2. Anhedonia or pervasive loss of interest in almost all activities
3. Appetite disturbance with change in weight (in children, failure to make expected weight gains)
4. Sleep disturbance
5. Psychomotor agitation or retardation
6. Decreased energy (including fatigue)
7. Feelings of guilt or worthlessness
8. Difficulty concentrating or thinking
9. Suicidal thoughts or acts
10. Hallucinations, delusions, or paranoid thinking

B. Manic Syndrome

1. Hyperactivity (increased activity or psychomotor agitation)
2. Pressure of speech (include discussion of any increased talkativeness)
3. Flight of ideas
4. Inflated self-esteem (grandiosity)
5. Decreased need for sleep
6. Involvement in activities that have a high probability of painful consequences which are not recognized
7. Hallucinations, delusions, or paranoid thinking

C. Bipolar Syndrome with a history of episodic periods manifested by the full symptomatic picture of both manic and depressive syndromes (and currently characterized by either or both syndromes)

VI. Does the patient have any of the following current marked limitations?

- A. Marked restriction of activities of daily living
- B. Marked difficulties in maintaining social functioning
- C. Marked difficulties in maintaining concentration, persistence, or pace
- D. Repeated episodes of decompensation, each of extended duration

VII. Does the patient have a history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, but with symptoms or signs currently attenuated by medication or psychosocial support?

Yes No Unknown

If **Yes**, indicate any of the following that apply.

- A. Repeated episodes of decompensation, each of extended duration.
- B. 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.
- C. 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.

VIII. For children under age 18 only.

Does the child have significant limitations in age-appropriate activities?

Yes No Unknown

If **Yes**, specify the age-appropriate limitations of which you are aware, citing specific developmental test results where possible.

A. For older infants and toddlers (age 1 to attainment of age 3)

1. Gross or fine motor development at a level generally acquired by children no more than one-half the child's chronological age

2. Cognitive/communicative function at a level generally acquired by children no more than one-half the child's chronological age

3. Social function at a level generally acquired by children no more than one-half the child's chronological age

4. Attainment of development or function generally acquired by children no more than two-thirds of the child's chronological age in two or more areas covered by **1, 2, or 3**

B. For children (age 3 to attainment of age 18)

1. Marked impairment in age-appropriate cognitive/communicative function

2. Marked impairment in age-appropriate social functioning

3. Marked impairment in age-appropriate personal functioning

4. Marked difficulties in maintaining concentration, persistence, or pace

IX. Specific residual functional capacities and limitations

Note: The following questions apply only to patients at least 18 years of age. Please assess each mental activity within the context of the patient’s ability to sustain that activity over a normal workday and workweek, on an ongoing basis.

	NOT SIGNIFICANTLY LIMITED	MODERATELY LIMITED	MARKEDLY LIMITED	UNKNOWN
A. UNDERSTANDING AND MEMORY	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
1. Ability to remember locations and work-like procedures.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
2. Ability to understand and remember very short and simple instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
3. Ability to understand and remember detailed instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
B. SUSTAINED CONCENTRATION AND PERSISTENCE	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
1. Ability to carry out very short and simple instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
2. Ability to carry out detailed instructions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
3. Ability to maintain attention and concentration for extended periods.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
4. Ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
5. Ability to sustain an ordinary routine without special supervision.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
6. Ability to work in coordination with or proximity to others without being distracted by them.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
7. Ability to make simple work-related decisions.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
8. Ability to complete a normal workday and workweek without interruptions from psychologically based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
C. SOCIAL INTERACTION	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
1. Ability to interact appropriately with the general public.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
2. Ability to ask simple questions or request assistance.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
3. Ability to accept instructions and respond appropriately to criticism from supervisors.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
4. Ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>
5. Ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	1. <input type="checkbox"/>	2. <input type="checkbox"/>	3. <input type="checkbox"/>	4. <input type="checkbox"/>

D. ADAPTATION

- | | | | | |
|--|-----------------------------|-----------------------------|-----------------------------|-----------------------------|
| | 1. <input type="checkbox"/> | 2. <input type="checkbox"/> | 3. <input type="checkbox"/> | 4. <input type="checkbox"/> |
| 1. Ability to respond appropriately to changes in the work setting. | 1. <input type="checkbox"/> | 2. <input type="checkbox"/> | 3. <input type="checkbox"/> | 4. <input type="checkbox"/> |
| 2. Ability to be aware of normal hazards and take appropriate precautions. | 1. <input type="checkbox"/> | 2. <input type="checkbox"/> | 3. <input type="checkbox"/> | 4. <input type="checkbox"/> |
| 3. Ability to travel in unfamiliar places or use public transportation. | 1. <input type="checkbox"/> | 2. <input type="checkbox"/> | 3. <input type="checkbox"/> | 4. <input type="checkbox"/> |
| 4. Ability to set realistic goals or make plans independently of others. | 1. <input type="checkbox"/> | 2. <input type="checkbox"/> | 3. <input type="checkbox"/> | 4. <input type="checkbox"/> |

(Use this space for discussion of evidence associated with residual functional capacity assessment.)

X. Additional Physician/Psychologist Comments

Physician or Psychologist Name (print or type)

Physician or Psychologist Signature (no name stamps)

Date