PARKINSON'S DISEASE
MEDICAL ASSESSMENT FORM

TO: Dr. _____

RE: _____

SSN: _____

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

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

2. Does your patient exhibit Parkinson's disease? ☐ Yes ☐ No

   a) Other diagnoses: _____

   b) Prognosis: _____

3. Please identify any **signs or symptoms** that your patient exhibits due to his/her impairments:

☐ Tremor	☐ Rigidity	☐ Bradykinesia	☐ Postural instability
☐ Seborrhea	☐ Saliva drooling	☐ Impaired gait	☐ Falls
☐ Chronic fatigue	☐ Blepharoclonus		

☐ Reduced intellectual function

☐ Impaired attention & concentration

☐ Impaired short term memory

☐ Impaired ability to arise from a seated position

☐ Soft/poorly modulated voice

4. If your patient exhibits **tremors**, characterize the nature and severity of the tremors and the parts of the body affected: _____
_____

5. Identify (or attach) any other positive clinical findings and test results: _____
_____

6. If your patient experiences symptoms which interfere with the **attention and concentration** needed to perform even simple work tasks, during a typical workday, please estimate the **frequency** of interferences:

☐ rarely ☐ occasionally ☐ frequently ☐ constantly

NOTE: 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***

7. If your patient was placed in a competitive job, identify those aspects of **workplace stress** that he/she 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?

☐ Yes ☐ No

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? _____

b) Please circle the hours and/or minutes that your patient can *continuously* **sit and stand** *at one time*:

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

What must your patient usually do after sitting this long?

☐ Walk ☐ Stand ☐ Lie Down ☐ Other: _____

Stand:	Minutes						Hours		
0	5	10	15	20	30	45	1	2	More than 2

What must your patient usually do after standing this long?

☐ Walk ☐ Stand ☐ Lie Down ☐ Other: _____

c) Please indicate how long your patient can sit and stand/walk *total in an eight-hour workday* (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*:

How many times during an average workday do you expect this to happen? (Circle selection)

0 1 2 3 4 5 6 7 8 9 10 More than 10

How long (on average) will your patient have to rest before returning to work? (Circle selection)

Minutes						Hours		
Less than 5	5	10	20	30	45	1	2	More than 2

What symptom(s) cause a need for breaks?

☐ Muscle weakness ☐ Pain/paresthesia, numbness

☐ Chronic fatigue ☐ Adverse effects of medication

☐ Other: _____

e) With prolonged sitting, should your patient's leg(s) be **elevated**?

☐ Yes ☐ No

If yes:

- How high should the leg(s) be elevated? _____
- If your patient had a sedentary job, what percentage of time during an *eight-hour workday* should the leg(s) be elevated? _____%
- What symptom(s) cause a need to elevate the leg(s)? _____

f) While engaging in even occasional standing/walking, must your patient use a cane or other assistive device(s) for balance?

☐ Yes ☐ No

If yes, what symptom(s) cause a need to use a cane or other device?

_____

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**:

What symptom(s) cause limitations with use of the upper extremities?

☐ Tremor ☐ Bradykinesia ☐ Sensory loss ☐ Rigidity

☐ Side effects of medication ☐ Other: _____

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 (including overhead)
Right	_____ %	_____ %	_____ %
Left	_____ %	_____ %	_____ %

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

- ☐ Never / less than once a month
- ☐ About once or twice a month
- ☐ About three days a month
- ☐ About four days a month
- ☐ More than four days a month

11. Would your patient exhibit difficulties sustaining speech in a job situation?

☐ Yes ☐ No

If yes, describe your patient's difficulties with speech? _____
_____
_____

12. Please describe any other limitations that would affect your patient's ability to work at a regular job on a sustained basis or any testing that would help to clarify the severity of your patient's impairment(s) or limitations: _____
_____
_____
_____
_____
_____

Date: _____

Signed: _____

Print Name: _____

Address: _____

Medical Statement regarding listing of impairments – Parkinson's Disease

RE: _____

Social Security Listing 11.06
Parkinsonian syndrome with the following signs:
Significant rigidity, bradykinesia or tremor in two extremities, which singly or in combination, result in sustained disturbance of gross and dexterous movements, or gait and station.

Patient _____ meets Listing 11.06.

Patient meets Listing 11.06 because: _____

_____

_____

_____

_____

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_____

_____

_____

_____

_____

Date: _____

Signed: _____

Print Name: _____

Address: _____