FIBROMYALGIA MEDICAL ASSESSMENT FORM

PROVIDER'S NAME: _____
PROVIDER'S TELEPHONE: _____

PATIENT'S NAME: _____
PATIENT'S DATE OF BIRTH: _____
PATIENT'S SS#: _____

Please answer the following questions about your patient's fibromyalgia and other impairment(s). Your answers should be based on the evidence in the patient's file and on your personal contact with and observations of the patient.

1. Date treatment began: _____
   Frequency of treatment (weekly/bi-weekly/monthly) _____
   Date of last appointment: _____

2. Does your patient meet the 2010 diagnostic criteria for fibromyalgia as defined by the American College of Rheumatology? Y / N

3. Does your patient experience widespread pain? Y / N

4. Does your patient exhibit signs of chronic fatigue syndrome? Y / N

5. Please indicate all of your patient's symptoms:

____ self-reported short-term memory impairment
____ self-reported concentration impairment
____ tender cervical lymph nodes
____ tender axillary lymph nodes
____ multi-joint pain w/o redness or swelling
____ recurrent and severe headaches
____ shortness of breath or breathlessness
____ recurrent and severe headaches
____ post-exertional malaise exceeding 24 hours
____ visual difficulties
____ diffuse muscle pain
____ leg cramps
____ restless leg
____ sore throat
____ muscle pain
____ un-refreshing sleep
____ chronic pain
____ IBS
____ carpal tunnel syndrome
____ vestibular dysfunction
____ menstrual disorders
____ hypothyroidism
____ orthostatic intolerance
____ parasthesia
____ depression/anxiety
____ sicca syndrome

6. Did your patient allege a specific onset date? Y / N
   If yes, what was the specific onset date of the symptoms? _____

7. Have these symptoms lasted for at least three months? Y / N

_____ (provider initials)

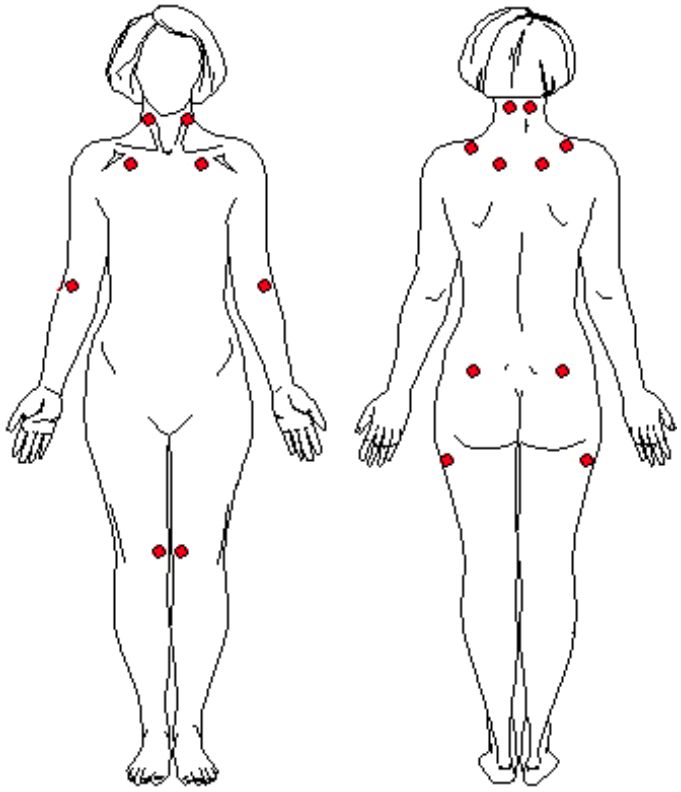
8. Are these symptoms related to emotional factors? Y / N

9. If your patient experiences chronic pain or parasthesia, please indicate the *severity* of the pain or parasthesia: ____ mild ____ moderate ____ severe

10. Please indicate which of the following tender points were positive for pain upon digital palpitation (of at least nine pounds pressure):

___ (L) shoulder girdle	___ (R) shoulder girdle
___ (R) upper arm	___ (L) upper arm
___ (R) lower arm	___ (L) lower arm
___ (R) hip (buttock, trochanter)	___ (L) hip (buttock, trochanter)
___ (R) upper leg	___ (L) upper leg
___ (R) lower leg	___ (L) lower leg
___ (R) jaw	___ (L) jaw
___ upper back	___ lower back
___ chest	___ abdomen

11. Please indicate the location of your patient's pain by shading the relevant body area. Please also label the frequency of pain as constant (C), frequent (F), or intermittent (I):



_____ (provider initials)

11. Please indicate any positive objective signs of your patient's impairment(s):

___ SLR left at ____%	___ tenderness	___weight change
right at ___%	___ crepitus	___ joint warmth
___ sensory changes	___joint changes	___ reflex changes
___ spasm	___ impaired sleep	___ atrophy
___ muscle weakness	___ impaired appetite	___ motor loss
___ abnormal gait	___ limitation in motion	___ joint instability
___ chronic fatigue	___ joint deformity	___ reduced grip strength

___ other: _____

12. Please identify any other positive clinical findings and test results (e.g., myelogram, MRI, CT scans, EMG/NCS, blood or other laboratory results):

_____

_____

13. Have all other possible causes of your patient's symptoms been ruled out? Y / N
If yes, what laboratory testing or imaging studies were performed to rule out other causes (e.g., myelogram, MRI, CT scans, EMG/NCS, blood or other laboratory results)?

_____

_____

_____

14. Do you believe your patient is a malingerer? Y / N

15. Must your patient elevate his or her legs with prolonged sitting? Y / N
If yes, how *high* should the legs be elevated? _____
If yes, what percentage of an 8-hour work-day must they be elevated? _____
If yes, what is the reason the legs must be elevated? _____

16. Has your patient's condition lasted, or is it expected to last, at least 12 consecutive months? Y / N

17. How often are your patient's symptoms likely to result in absenteeism from work (due to treatment or other causes)?

☐Never	☐About one day per month
☐About two days per month	☐About three days per month
☐About four days per month	☐More than four days per month

18. Identify any side effects of medications that may have implications for working (e.g., dizziness, drowsiness, stomach upset):

_____

_____

_____

_____ (provider initials)

19. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a ***competitive work situation*:**

    a. How many city blocks can your patient walk without rest or severe pain?

    _____

    b. Please circle the hours and/or minutes that your patient can sit ***at one time*** (that is, before needing to get up):

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

    c. Please circle the hours and/or minutes that your patient can stand ***at one time*** (that is, before needing to sit down or walk around):

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

    d. Please indicate the total number of house your patient can sit and stand/walk in an 8-hour working day (with normal breaks):

Sit	Stand/Walk	
☐	☐	less than two hours
☐	☐	about two hours
☐	☐	about four hours
☐	☐	at least six hours

20. Does your patient need a job that permits shifting positions ***at will*** between sitting, standing, and walking? Y / N

    a. If so, please indicate how ***frequently*** your patient must shift positions:

    5 10 15 20 25 30 35 40 45 50 55 60
    Minutes

    b. If your patient must walk to shift positions, please indicate for ***how long***:

    5 10 15 20 25 30 35 40 45 50 55 60
    Minutes

21. While engaging in occasional standing/walking, must your patient use a cane or other assistive device? Y / N

_____ (provider initials)

22. Will your patient need ***unscheduled*** breaks throughout a normal 8-hour work day? Y / N

a. If so, please indicate how ***frequently*** your patient will need to take breaks:

5 10 15 20 25 30 35 40 45 50 55 60
Minutes

b. If so, please indicate ***how long*** your patient must take each break:

5 10 15 20 25 30 35 40 45 50 55 60
Minutes

c. If so, will your patient need to lie down? Y /N Sit quietly? Y / N

For the next three questions, please use the following definitions:
"Rarely" means 1% to 5% of an 8-hour work day, or about 5 to 25 minutes.
"Occasionally" means 6% to 33% of an 8-hour work day, or about ½ hour to 2 ½ hours.
"Frequently" means 34% to 66% of an 8-hour work day, or about 2 ¾ hours to 5 ¼ hours.

23. How many pounds can your patient lift and carry in a competitive work situation?

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

24. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Stoop	☐	☐	☐	☐
Bend	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Climb ladders	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐

25. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Look down	☐	☐	☐	☐
Turn head left or right	☐	☐	☐	☐
Look up	☐	☐	☐	☐
Hold head in static position	☐	☐	☐	☐

26. If your patient has significant limitations with reaching, handling, or fingering, please indicate the percentage of time during an 8-hour working day that your patient can use his hands/fingers/arms for the following activities:

	Hands (*grasp, turn, twist objects)*	**Fingers** *(fine manipulation)*	**Arms** *(reaching in front)*	**Arms** *(reaching overhead)*
Right:	%	%	%	%
Left:	%	%	%	%

27. Please indicate whether your patient experiences any of the following mental impairments as a results of his or her diagnosis:

Difficulty with short-term memory	☐
Difficulty following simple directions	☐
Impaired social interaction	☐
The ability to adjust to routine work changes	☐
Confusion	☐
"Fuzzy" thinking	☐
Distractibility	☐
Difficulty with word use and recall	☐
Difficulty with routine problem solving	☐
Disorientation to time and place	☐

28. If your patient suffers from any of the above mental impairments, please indicate the extent to which the impairment(s) are likely to interfere with his or her ability to complete an 8-hour workday:

0%	5%	10%	15%	20%	25% or more
☐	☐	☐	☐	☐	☐

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

☐Cannot tolerate even "low stress" work
☐Can tolerate low stress work
☐Can tolerate moderate stress (normal work)
☐Can tolerate high stress work

30. Does your patient experienced "good days" and "bad days"? Y / N

_____ (provider initials)

31. Are your patient's impairments (physical impairments plus any emotional impairments) as demonstrated by signs, clinical findings, and laboratory or test results, ***reasonably consistent*** with the symptoms and functional limitations described above in this evaluation? Y / N

If no, please explain:

_____

_____

_____

_____

_____

_____

_____

_____

_____ _____

DATE SIGNATURE

_____

PRINT NAME

_____

YOUR CLINIC / FACILITY / OFFICE