

Patient Name _____
First Middle Last

Group Number _____

This Supplemental Questionnaire is designed to answer certain questions about the claimant's residual functional capacity. It is essential that your answers be based on your estimate of the claimant's current psychiatric impairment and not on nonpsychiatric medical factors or nonmedical factors such as availability of job openings, hiring practices of employers, etc.

Definitions of Rating Terms:

None	No impairment in this area
Mild	Suspected impairment of slight importance which does not affect ability to function
Moderate	An impairment which affects but does not preclude ability to function
Moderately Severe	An impairment which seriously affects ability to function
Severe	Extreme impairment of ability to function

	<i>None</i>	<i>Mild</i>	<i>Moderate</i>	<i>Moderately Severe</i>	<i>Severe</i>
1) Estimated degree of impairment of the claimant's ability to relate to other people	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2) Estimated degree of restriction of daily activities, e.g. ability to attend meetings (church, lodge, etc.)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3) Estimated degree of deterioration in personal habits of the claimant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4) Estimated degree of constriction of interests of the claimant	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5) Based on your evaluation of the claimant's psychiatric status, please give your opinion as to the limitations in the claimant's ability to do the following on a sustained basis in a routine work setting.					
(a) Understand, carry out and remember instructions	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(b) Respond appropriately to supervision	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(c) Respond appropriately to co-workers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(d) Respond to customary work pressures	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(e) Perform simple tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(f) Perform complex tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
(g) Perform varied tasks	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6) Duration of Impairment:					
Have the above limitations lasted or can they be expected to last for 12 months or longer?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
What is your opinion as to the earliest date the same level of severity existed?	_____				
7) Was a psychological evaluation obtained?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
If "Yes", was the psychological evaluation considered in the determination of disability?	<input type="checkbox"/> Yes <input type="checkbox"/> No				
If not, please explain why	_____				

8)	What are the side effects, if any, if the claimant is taking any medication(s)?
9)	If the claimant alleges pain, are the allegations consistent with clinical findings? <input type="checkbox"/> Yes <input type="checkbox"/> No If pain is present, how does it affect the claimant's ability to function?
10)	Initial Treatment Date ____/____/____
11)	Date the claimant first became disabled ____/____/____
12)	Date of most recent examination ____/____/____
13)	Is claimant hospital confined? <input type="checkbox"/> Yes <input type="checkbox"/> No
14)	If "Yes", has the claimant been confined for at least 14 days? <input type="checkbox"/> Yes <input type="checkbox"/> No
15)	Is the claimant undergoing convulsive therapy treatment? <input type="checkbox"/> Yes <input type="checkbox"/> No
16)	Is the patient now totally disabled... For any occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No For his/her occupation? <input type="checkbox"/> Yes <input type="checkbox"/> No
17)	Return to work date... For any occupation ____/____/____ For his/her occupation? ____/____/____
18)	In view of the above limitations of your patient, do you feel he/she is a good candidate for a rehabilitation program at this time? <input type="checkbox"/> Yes <input type="checkbox"/> No
19)	A. Primary Diagnosis affecting work ability _____ B. Secondary Diagnosis affecting work ability _____
20)	Comments _____ _____ _____ _____ _____ _____
	Physician's Name _____ Physician's Address _____ _____ Signature _____ Date _____