HEADACHES MEDICAL SOURCE STATEMENT

From: _____

Re: _____ (Name of Patient)

_____ (Social Security No.)

Please answer the following questions concerning your patient's impairments. *Refer to relevant treatment notes, radiologist reports, laboratory, and test results as appropriate.*

1. Frequency and length of contact: _____
2. Diagnoses: _____
3. Prognosis: _____
4. What tests or observations were used to determine your patient's diagnoses?

_____

_____

_____

5. Please describe the intensity of your patient's headaches:

_____

_____

6. List your patient's other ***symptoms***, including aura, nausea, dizziness, fatigue, etc:

_____

_____

_____

7. Please identify any observable ***medical signs*** associated with your patient's headaches:

_____

_____

_____

8. What is the approximate frequency of your patient's headaches?

_____

_____

9. What is the approximate duration of a typical headache?

_____

_____

10. Please list any identifiable triggers:

_____

_____

11. What makes your patient's headaches better?

12. How long does it take for your patient to return to regular activity after a headache?

13. How do these symptoms / impairments interfere with your patient's ability to work eight hours per day, five days per week?

14. How frequently would your patient require unscheduled breaks during the workday to rest because of symptoms? _____

15. How well can your patient tolerate work stress? _____

16. Please describe any other **limitations** (such as psychological limitations, 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:

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

Please return completed form to:
The Hardin Law Firm, PLC
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Fax: (501) 421-9237