MEDICAL SOURCE STATEMENT (MENTAL)
For Treating Physician To Complete

NAME: ______________________ SSN: ______________________

Diagnosis: ____

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INDICATE CURRENT LIMITATIONS FROM THE ABOVE IMPAIRMENT(S)

Ability To Relate And Interact With Supervisors And Co-Workers:
[ ] Not Significantly limited or unknown [ ] Moderately limited
[ ] Mildly limited [ ] Markedly limited [ ] Extremely limited

Ability To Understand, Remember and Carry Out An Extensive Variety Of Technical And/Or Complex Job Instructions:
[ ] Not Significantly limited or unknown [ ] Moderately limited
[ ] Mildly limited [ ] Markedly limited [ ] Extremely limited

Ability To Understand, Remember and Carry Out Simple One-Or-Two Step Job Instructions:
[ ] Not Significantly limited or unknown [ ] Moderately limited
[ ] Mildly limited [ ] Markedly limited [ ] Extremely limited

Ability To Deal With The Public:
[ ] Not Significantly limited or unknown [ ] Moderately limited
[ ] Mildly limited [ ] Markedly limited [ ] Extremely limited

Ability To Maintain Concentration And Attention For At Least Two Hour Increments:
[ ] Not Significantly limited or unknown [ ] Moderately limited
[ ] Mildly limited [ ] Markedly limited [ ] Extremely limited

Ability To Withstand The Stress And Pressures Associated With An Eight-Hour Work Day and Day-To-Day Work Activity:
[ ] Not Significantly limited or unknown [ ] Moderately limited
[ ] Mildly limited [ ] Markedly limited [ ] Extremely limited

Ability To Handle Funds:
[ ] Not Significantly limited or unknown [ ] Moderately limited
[ ] Mildly limited [ ] Markedly limited [ ] Extremely limited

Indicate any other work-related limitations, including those resulting from prescribed medications:

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How long have the above limitations existed? ______________________

To what extent has drug addiction or alcoholism contributed to the above limitations:
[ ] None or not significantly [ ] Moderately
[ ] Mildly [ ] Markedly [ ] Extremely

I understand that the above information will be used in consideration for Social Security benefits. I understand that making a false statement or representation herein may subject me to criminal prosecution for fraud.

Print Last Name	Physician Signature	Title	Date