

CLAIMANT:
CASE NUMBER:

SHORT-FORM EVALUATION FOR MENTAL DISORDERS

Directions: Please provide a current assessment necessary to evaluate this patient's disability claim. The information must be as objective and specific as possible. **THIS FORM MAY BE USED ONLY WHEN A PRIOR EVALUATION AND CHART NOTES ARE AVAILABLE.**

Date first examined: _____	Type of Service:
Date of most recent visit: _____	_____ Outpatient
Frequency of Visits: _____	_____ Partial Hospitalization
Diagnosis	_____ Case Management
(DSM IV) (Indicate Principal Diagnosis)	_____ Medication
	(list type and dosage)
Axis I _____	_____
_____	_____
_____	_____
Axis II _____	

CURRENT MENTAL STATUS EXAMINATION: (Circle and comment on abnormal findings)

Appearance and Behavior:

Grooming: Well-groomed, disheveled, eccentric, poor hygiene.

Motor Activity: Normal, tremor, retarded, agitated, hyperactive.

Speech: Normal, slow, rapid, pressured, slurred, mute, delayed, soft, loud, stuttering, aphasic.

Interview Behavior: Cooperative, guarded, evasive.

Behavior Disturbance: None, irritable, aggressive, violent, poor impulse control, manipulative, apathetic.

Comments: _____

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Sensorium and Cognitive Functioning:

Orientation: Oriented all spheres, disoriented (person, place, time, situation)

Concentration: Intact, slightly distracted, impaired (mild, moderate, severe)

Memory: Normal, impaired (immediate, recent, remote) and degree (mild, moderate, severe).

Intelligence: Above average, average, below average, borderline, mental retardation.

Comments: _____

Mood and Affect:

Mood: Normal, anxious, depressed, fearful, elated, euphoric, angry.

Affect: Appropriate, labile, expansive, blunted, flat

Comments: _____

Perception:

Hallucinations: None, auditory, visual, olfactory.

Illusion: None, misidentification

Specify: _____

Thought Process:

Associations: Goal directed, blocking, circumstantial, tangential, loose, neologisms.

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Content-Delusions: None, persecution, somatic, broadcasting, grandiosity, religious, nihilistic, ideas of reference.

Content-Preoccupations: None, obsessions, compulsions, phobias, sexual, suicidal, homicidal, depersonalization.

Judgment: Intact, impaired (mild, moderate, severe).

Comments: _____

ALCOHOL AND DRUG ABUSE:

Current alcohol use: None, social, abuse (occasional, binge pattern, daily). Specify Type and Amount: _____

Current illicit drug use: None, abuse (occasional, episodic, daily), cannabis, cocaine, heroin, amphetamines, sedatives, hallucinogens, hypnotic, inhalants.
Amounts: _____

Detox, Drug Program or Tox Screen: (Specify dates and results)

History alcohol/drug abuse: None, none in past 6 months, none in past ___ years, continuous since _____

PROGRESS IN TREATMENT AND PROGNOSIS:

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PLEASE USE THESE DEFINITIONS WHEN CHECKING THE BOXES BELOW.

Unlimited - The mental disorder does not affect the ability to perform this activity.

Good - The effects of the mental disorder do not significantly limit the individual from consistently and usefully performing the activity.

Fair - The evidence supports the conclusion that the individual's capacity to perform the activity is impaired, but the degree/extent of the impairment needs to be further described.

Poor - The evidence supports the conclusion that the individual cannot usefully perform or sustain the activity.

MEDICAL SOURCE STATEMENT	Unlimited	Good	Fair	Poor
Understand, remember, and carry out complex instructions				
Understand, remember, and carry out simple instructions				
Maintain concentration, attention and persistence				
Perform activities within a schedule and maintain regular attendance				
Complete a normal workday and workweek without interruptions from psychologically based symptoms				
Interact appropriately with the public				
Interact appropriately with supervisors				
Interact appropriately with co-workers				
Respond appropriately to changes in a work setting				

Do you believe this patient is capable of managing funds in his or her own best interest? Yes No

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Name of reporting Psychiatrist/Psychologist (Print or type)

Address _____	Signature _____
City/State _____	Title _____
Telephone _____	Date _____