DISORDERS OF THE SPINE
TREATING PHYSICIAN
DATA SHEET

Short form

FOR REPRESENTATIVE USE ONLY

REPRESENTATIVE'S NAME AND ADDRESS

REPRESENTATIVE'S TELEPHONE

REPRESENTATIVE'S EMAIL

PHYSICIAN'S NAME AND ADDRESS

PHYSICIAN'S TELEPHONE

PHYSICIAN'S EMAIL

PATIENT'S NAME AND ADDRESS

PATIENT'S TELEPHONE

PATIENT'S EMAIL

PATIENT'S SSN

TYPE OF CLAIM:

Title 2 ☐ DIB/DWB ☐ CDB

Title 16 ☐ DI ☐ DC

LEVEL OF ADJUDICATION:

Initial DDS ☐ Recon DDS ☐

Initial CDR ☐ Hearing Officer ☐

Administrative Law Judge ☐ Appeals Council ☐

Federal District Court ☐ Federal Appeals Court ☐

Dear Dr.

We are pursuing the Social Security disability claim for the above-named individual (the "patient"). We understand how valuable your time is, and this data sheet has been designed to allow you to provide medical information in an efficient and organized way. As a treating physician, your records and medical judgment are vital in arguing for a fair disability determination for the patient before the Social Security Administration (SSA). If you receive multiple data sheets, please disregard repetitive questions.

Your medical specialty please:

Note 1: This document will not have legal validity for Social Security disability determination purposes unless completed by a licensed medical doctor or osteopath.

Note 2: This document only concerns disorders of the spine. Other impairments and limitations resulting from a combination of impairments should be considered separately.

Note 3: Age, degree of general physical conditioning, sex, body habitus (i.e., natural body build, physique, constitution, size, and weight), insofar as they are unrelated to the patient's medical disorder and symptoms, should not be considered when assessing the functional severity of the impairment.

"Occasionally" means very little up to 1/3 of an 8 hour workday.

"Frequently" means 1/3 to 2/3 of an 8 hour workday.

I. What is the medical impairment (e.g., herniated nucleus pulposus, spinal arachnoiditis, spinal stenosis, osteoarthritis, degenerative disc disease, facet arthritis, vertebral fracture) that results in compromise of a nerve root (including the cauda equina), spinal cord, or spinal pain.

Note: Please describe the spinal anatomical location of the abnormality cited.

II. Has surgery been done or planned?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please specify the types of surgery and dates.

III. Has treatment significantly improved pain?

☐ **Yes** ☐ **No** ☐ **Unknown**

Medications and doses

Additional comments

IV. Certain Specific Diagnoses, limitations, and capacities.

Note 1: The limiting effects of pain or other symptoms should be included in assessment of functional loss.

Note 2: If the patient uses any type of orthotic or prosthetic device, questions pertain to function while using such devices.

Note 3: For disability determination purposes, the SSA requires that a non-blind impairment be disabling for a minimum of 12 months. If the patient is not 12 months post-op, please offer your best estimation of what the patient's functional condition will be 12 months post-op.

A. Evidence of nerve root compression

1. Does the patient have limitation of lumbar spinal motion?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **No**, go to B.

If **Yes**, what are the limited motions?

2. Does the patient have limitation of cervical spinal motion?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, what are the limited motions?

3. If nerve root compression is thought to be present in the lower back, please specify straight leg raising (SLR) findings (degrees).

4. Please specify the results of any imaging studies (MRI, CT, myelography) that are compatible with nerve root compression (or attach report).

Has the patient had surgery since the above imaging studies?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, what was the surgery?

5. Are there current sensory abnormalities?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please give the dermatomal distribution:

6. Are there current reflex abnormalities?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please specify:

7. Is there current weakness and muscle atrophy?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please describe:

B. Does the patient have arachnoiditis?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **No**, go to C.

If **Yes**, please specify how the diagnosis was made.

Does the patient need to change body position or posture to lessen otherwise intractable pain?

☐ **Yes** ☐ **No** ☐ **Unknown**

If Yes, please check the boxes that apply.

- ☐ Every 30 minutes
- ☐ Every 1 hour
- ☐ Every 2 hours
- ☐ Every 3 hours
- ☐ Every 4 hours
- ☐ Every 6 hours

C. Does the patient have lumbar spinal stenosis?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please answer the following questions.

If **No**, go to D.

1. What neuroimaging technique was used to show spinal stenosis?
   - ☐ Magnetic resonance imaging (MRI)
   - ☐ Computerized axial tomography (CAT)
   - ☐ Myelography
   - ☐ Patient currently complains of chronic pain and nonradicular weakness

   Was decompressive surgery performed?

   ☐ **Yes** ☐ **No** ☐ **Unknown**

   Did surgery significantly relieve pain?

   ☐ **Yes** ☐ **No** ☐ **Unknown**

2. Does the patient currently have pseudoclaudication?

   ☐ **Yes** ☐ **No** ☐ **Unknown**

   If **Yes**, please describe symptoms.

3. Ambulatory ability

   a. Can the patient ambulate without the use of a hand-held assistive device that limits the functioning of both upper extremities?

   ☐ **Yes** ☐ **No** ☐ **Unknown**

   b. Can the patient sustain a reasonable walking pace over a sufficient distance to be able to carry out activities of daily living?

   ☐ **Yes** ☐ **No** ☐ **Unknown**

D. Does the patient have osteoporosis of the spine?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please provide the following information.

If **No**, please go to E.

Imaging was done by: ☐ Densitometry (attach report if available)
☐ Plain x-ray (attach report if available)

Are there pathologic (non-traumatic) vertebral fractures?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please specify the location, number and severity of the fractures.

What is the cause of osteoporosis (e.g., post-menopausal)?

E. Does the patient have scoliosis or other spinal deformity?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, please specify the nature, location, and severity of the curvatures or other deformities.

If **No**, go to **Section V**.

Is there over ½ inch leg length discrepancy?

☐ **Yes** ☐ **No** ☐ **Unknown**

Has treatment significantly relieved pain?

☐ **Yes** ☐ **No** ☐ **Unknown**

V. Residual functional capacities and limitations (all diagnoses)

Note: The following questions apply only to patients at least 18 years of age. For younger children, please discuss any known limitations in age-appropriate activities in Section VI.

1. Does the patient have the ability to stand and/or walk 6 – 8 hours daily on a long term basis?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **No**, how long can the patient stand and/or walk (with normal breaks) in a 6 – 8 hour work day?

2. What maximum weight can the patient lift and/or carry occasionally (cumulatively not continuously)?

☐ **Unknown**

- ☐ Less than 10 lbs.
- ☐ 10 lbs.
- ☐ 20 lbs.
- ☐ 50 lbs.
- ☐ 100 lbs.
- ☐ Other (lbs.)

3. What weight can the patient lift and/or carry frequently (cumulatively not continuously)?

☐ **Unknown**

- ☐ Less than 10 lbs.
- ☐ 10 lbs.
- ☐ 20 lbs.
- ☐ 50 lbs. or more
- ☐ Other (lbs.)

4. How often can the patient bend (stoop) while carrying the above weight?

☐ Never ☐ Occasionally ☐ Frequently ☐ **Unknown**

5. Can the patient tolerate significant vibration while seated?

☐ Never ☐ Occasionally ☐ Frequently ☐ **Unknown**

VI. For children under age 18 only.

Note: The limiting effects of pain or other symptoms should be included in assessment of functional loss.

Does the child have significant limitations in age-appropriate activities?

☐ **Yes** ☐ **No** ☐ **Unknown**

If **Yes**, specify the age-appropriate limitations of which you are aware, citing specific developmental test results where possible.

VII. Additional Physician Comments

_____

Physician's Name (print or type)

_____

Physician's Signature (no name stamps)

_____

Date