Mental Residual Functional Capacity Form/Medical Opinion Statement

Patient Name: *Fernanda Martinez* **Date of Birth:** 08/13/1979

Social Security #: 999-11-0000

Please respond to the following questions regarding your patient's ability to perform work-related mental activities. When answering the questions, please be specific with regards to what evidence in your patient's records supports your opinion. This will be used as medical evidence for a Social Security disability claim or a private long-term disability claim.

Section A: Medical History

1. When did you begin treating the patient?

   I first saw Ms. Martinez on January 23, 2020.

2. How often do you see the patient?

   We have scheduled in-person visits twice every month. Each visit lasts one hour.

3. What is your current diagnosis of the patient's mental impairment(s)?

   Major Depressive Disorder, Recurrent

4. What symptoms or signs did you evaluate that led to your diagnosis?

   Ms. Martinez frequently presents to my office with flat affect and depressed mood. She is tearful on occasion and speaks in a low monotone.

5. Were any tests, assessments, or evaluations performed that support your diagnosis?

   Ms. Martinez completed a depression questionnaire in which she endorsed anhedonia, poor appetite, and feelings of worthlessness nearly every day, as well as fatigue, trouble concentrating, and oversleeping more than half of the time.

6. What is your prognosis for the patient (good, fair, poor)?

   Poor. Despite making some progress, Ms. Martinez has a long way to go before her symptoms of depression are under control.

7. Are you aware of any physical medical condition that may contribute to the patient's mental impairment? ✓ Yes _____No

If yes, please describe:

Ms. Martinez reports back pain due to a herniated disc in her lumbar spine.

8. What treatments has the patient undergone?

Medications (SSRIs at high dosages) and cognitive behavioral therapy.

9. Is the patient compliant with treatment? ✓ Yes _____No

If no, please describe why your patient was unable to comply with treatment:

_____

_____

10. What is the patient's highest GAF this past year? 50 Current GAF? 31

Section B: Functional Limitations

Based on your personal assessment of the patient, please circle the word that best describes the patient's functioning in the associated category, using the definitions provided below. Assume that these activities must be performed on a regular and sustained basis (40 hours per week).

None: The patient can function independently in this area on a sustained basis.
Mild: The patient has slight limitations in sustained, independent functioning.
Moderate: The patient's ability to function independently in this area is fair.
Marked: The patient' ability to function independently in this area is seriously limited.
Extreme: The patient is unable to sustain function independently in this area.
Not Ratable: There is no evidence available to assess the ability to function.

I. Understanding and Memory

a. The ability to remember locations and work-like procedures.

None *Mild* *Moderate* (*Marked*) *Extreme* *Not Ratable*

b. The ability to understand and remember very short, simple instructions.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

c. The ability to understand and remember detailed instructions.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

II. Concentration and Persistence

a. The ability to carry out very short, simple instructions.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

b. The ability to carry out detailed instructions.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

c. The ability to maintain attention and concentration for extended periods.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

d. The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

e. The ability to sustain an ordinary routine without special supervision.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

f. The ability to work with or in proximity to others without being distracted by them.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

g. The ability to make simple work-related decisions.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

h. The ability to complete a normal workday and workweek without interruptions from psychologically based symptoms, and to perform at a consistent pace without an unreasonable number or length of rest periods.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

III. Social Interaction

a. The ability to interact appropriately with the general public.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

b. The ability to ask simple questions or request assistance.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

c. The ability to accept instructions and respond appropriately to criticism from supervisors.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

d. The ability to get along with coworkers or peers without distracting them or exhibiting behavioral extremes.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

f. The ability to maintain socially appropriate behavior and adhere to basic standards of neatness and cleanliness.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

IV. Adaptation

a. The ability to respond appropriately to changes in the work setting.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

b. The ability to be aware of normal hazards and take appropriate precautions.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

c. The ability to get around in unfamiliar places or use public transportation.

None *Mild* *Moderate* *Marked* *Extreme* *Not Ratable*

d. The ability to set realistic goals or make plans independently of others.

None *Mild* *Moderate* *(Marked)* *Extreme* *Not Ratable*

e. The ability to tolerate normal levels of stress.

None *Mild* *Moderate* *(Marked)* *Extreme* *Not Ratable*

Section C: Professional Observations

11. Would you estimate that your patient's impairment will substantially interfere with the ability to work at least 20% of the time? ✓ Yes _____No

12. How many days per month would your patient need to miss work due to symptoms of or treatment for the mental impairment?

At least 3 days per month.

13. Do you believe the patient can manage their own funds? ✓ Yes _____No

If no, please explain:_____
_____

14. Does your patient have a history of drug or alcohol abuse? _____Yes _✓No

If yes, would your patient's symptoms exist or persist despite drug or alcohol use?
_____ Yes _____No

15. Does your patient exaggerate symptoms? _____Yes _✓No

16. Do you expect the patient's limitations to last at least one year? ✓ Yes _____No

17. On what date did these limitations begin?

These symptoms have existed since I first treated Ms. Martinez on January 23, 2020.

18. In your opinion, are your patient's limitations reasonably consistent with the medical evidence and mental evaluations as a whole? ✓ Yes _____No

Doctor's Name and Signature: Mel Jepsen, M.D., Psy.D. **Date:** September 26, 2024

Doctor's Address: 121 Peachtree Lane, Lithonia, GA 30023