Fibromyalgia Medical Assessment Form

Patient Name: *Dana Capaldi* **Date of Birth:** *02/02/1974*

Social Security #: *999-11-0101*

Please respond to the following questions about your patient's fibromyalgia and other impairments. Your answers should be based on the evidence in your patient's file and on your personal contact with and observations of the patient.

Section A: Medical History

1. What date did you begin treating the patient?

July 11, 2021

2. How frequently do you see the patient (weekly/bi-weekly/monthly)?

Monthly until February 8, 2023, and then bi-weekly since that date.

3. What is the date of your last appointment with the patient?

September 29, 2024

4. Does your patient meet the diagnostic criteria for fibromyalgia under the 1990 American College of Rheumatology (ACR) Criteria for the Classification of Fibromyalgia or the 2010 ACR Preliminary Diagnostic Criteria? __✓_Yes _____No

5. Does your patient experience widespread pain? _✓ _Yes _____No

6. Does your patient experience signs of chronic fatigue syndrome? _✓ _Yes _____No

7. Please indicate all of your patient's symptoms:

__✓_self-reported short-term memory impairment
__✓_self-reported concentration impairment
__✓_tender cervical lymph nodes
__✓_tender axillary lymph nodes
__✓_multi-joint pain without redness or swelling
__✓_recurrent and severe headaches
__✓_shortness of breath
__✓_post-exertional malaise exceeding 24 hours
_____sore throat
__✓_muscle pain
__✓_unrefreshing sleep
__✓_chronic pain
_____irritable bowel (IBS)
_____carpal tunnel syndrome
__✓_vestibular dysfunction
_____menstrual disorders

_____visual difficulties
__✓_diffuse muscle pain
__✓_leg cramps or restless legs
__✓_depression or anxiety
_____hypothyroidism
__✓_orthostatic intolerance
__✓_paresthesia
_____Sjogren's syndrome

8. Does your patient allege a specific onset date? __✓_Yes _____No

If yes, what was the specific onset date of the symptoms?

Ms. Capaldi reported experiencing these symptoms for five months before establishing medical treatment with our practice.

9. Have these symptoms lasted for at least three months? __✓_Yes _____No

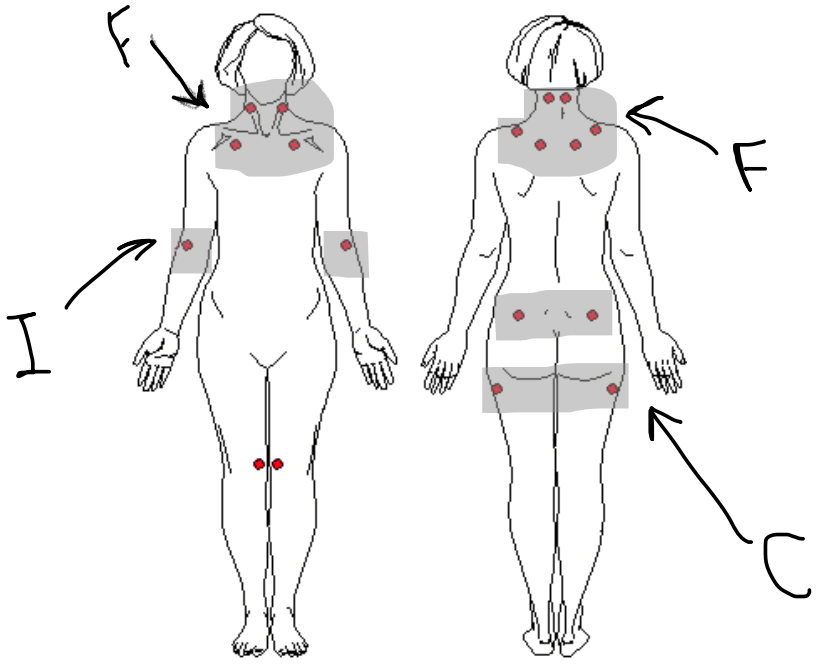
10. Are these symptoms related to emotional factors? _____Yes __✓_No

11. If your patient experiences chronic pain or paresthesia, please indicate the severity of the pain or paresthesia: _____mild _____moderate __✓_severe

12. Please indicate which of the following trigger points were positive with pain upon digital palpitation (of at least nine pounds pressure):

__✓_ (L) shoulder girdle
__✓_L) upper arm
__✓_ (L) lower arm
__✓_L) hip (buttock, trochanter)
__✓_ (L) upper leg
__✓_ (L) lower leg
_____(L) jaw
__✓_upper back
_____chest
__✓_ (R) shoulder girdle
__✓_R) upper arm
__✓_ (R) lower arm
__✓_ (R) hip (buttock, trochanter)
__✓_R) upper leg
__✓_ (R) lower leg
_____(R) jaw
__✓_lower back
_____abdomen

13. Please indicate the location of your patient's pain by shading the relevant body area on the diagram below. Please also label the frequency of the pain as constant (C), frequent (F), or intermittent (I):



14. Please indicate any positive objective signs of your patient's impairment:

__✓_SLR (left at _55__%)	__✓_tenderness	__✓_weight change
__✓_SLR (right at _55__%)	_____crepitus	_____joint warmth
__✓_sensory changes	_____joint changes	__✓_reflex changes
__✓_spasm	__✓_impaired sleep	_____atrophy
__✓_muscle weakness	_____poor appetite	__✓_motor loss
__✓_abnormal gait	__✓_reduced ROM	__✓_joint instability
__✓_chronic fatigue	_____joint deformity	__✓_reduced grip strength

_____other:_____

15. Please identify any other positive clinical findings and test results (for example, myelogram, MRI, CT scans, EMG/NCS, blood or other laboratory results:

Ms. Capaldi underwent a nerve conduction study on January 30, 2023, that demonstrated significant latency in her ulnar and sciatic nerves.

16. Have all other possible causes of your patient's symptoms been ruled out? _✓_Yes ____No

If yes, what laboratory testing or imaging studies were performed to rule out other c causes?

Ms. Capaldi underwent an X-ray and MRI of the cervical and lumbar spine to rule out degenerative disc disease. The results showed only mild degeneration of the vertebra, which wouldn't explain Ms. Capaldi's significant signs and symptoms.

Section B: Functional Limitations

17. Does your patient have limitations in their ability to stand? _✓_Yes ____No

If yes, please circle the number that best describes the total amount your patient can stand in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can stand at one time before they need to sit down (in minutes or hours)?

Between 15 to 30 minutes, depending on the day.

18. Does your patient have limitations in their ability to walk? _✓_Yes ____No

If yes, please circle the number that best describes the total amount your patient can walk in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can walk at one time before they need to sit down (in minutes, hours, or distance)?

Ms. Capaldi can walk about a quarter of a mile on even ground before she needs to sit down and relieve pain in her legs.

Does your patient require an ambulatory aid, such as a walker or cane? ____Yes _✓_No

I haven't yet prescribed Ms. Capaldi an ambulatory aid, but I have witnessed her leaning against walls for support while standing and she reports using a walking stick in her daily life.

19. Does your patient have limitations in their ability to sit? _✓_Yes ____No

If yes, please circle the number that best describes the total amount your patient can sit in an 8-hour workday:

Less than 2 hours | 2 hours | 4 hours | 6 hours

What is the longest your patient can sit at one time before they need to get up (in minutes or hours)?

Between 30-45 minutes, depending on the day.

20. Does your patient have limitations on lifting and carrying? _✓_Yes ____No

If yes, please circle the number that best describes the heaviest amount, in pounds, that your patient can *occasionally* (up to 1/3 of the workday) lift or carry:

Less than 10# | 10# | 20# | 50# | 100#

Please circle the number that best describes the heaviest amount, in pounds, that your patient can *frequently* (up to 2/3 of the workday) lift or carry:

Less than 10# | 10# | 20# | 50# | 100#

21. Does your patient need to be able to change positions at will? _✓_Yes ____No

If yes, how often do you think your patient will need to shift positions during the workday?

If she is working upright, I believe Ms. Capaldi would need to sit down on average every 20 minutes for about 5 to 10 minutes at a time.

22. Does your patient need to be able to lie down during the day? _✓_Yes ____No

If yes, how often do you think your patient will need to lie down during the day and for how long?

If she is working while seated, I believe Ms. Capaldi would need to lie down for about 15 minutes after every hour of work in hour to relieve pain in her back.

23. Does your patient need to be able to elevate their legs? ____Yes _✓_No

If yes, how long does your patient need to elevate their legs for and at what height (e.g., at waist level)?

_____

24. Please check the box that best describes how often your patient can perform the following actions in an 8-hour workday:

	Rarely or Never (very little, if at all)	Occasionally (up to 1/3 of the day)	Frequently (1/3-2/3 of the day)
Twist	☒	☐	☐
Bend	☒	☐	☐
Crouch	☒	☐	☐
Climb stairs	☐	☒	☐
Climb ladders	☒	☐	☐
Kneel	☒	☐	☐
Crawl	☒	☐	☐

25. Does your patient have limitations in the upper extremities? __✓_Yes ____No

If yes, please check the box that best describes how often your patient can use their arms, hands, and fingers to perform the following activities:

	Rarely or Never (very little, if at all)	Occasionally (up to 1/3 of the day)	Frequently (1/3-2/3 of the day)
Reaching overhead	☒	☐	☐
Reaching laterally	☐	☒	☐
Handling	☐	☒	☐
Fingering	☐	☒	☐
Feeling	☐	☒	☐
Grasping	☐	☒	☐

26. Are your patient's symptoms exacerbated by exposure to certain environmental conditions? _✓_Yes ____No

If yes, please check the box that best describes how often your patient should come into contact with the following factors:

	Avoid All Exposure	Avoid Concentrated Exposure	Avoid Moderate Exposure	No Restrictions
Extreme cold	☐	☒	☐	☐
Extreme heat	☐	☒	☐	☐
Wetness	☐	☒	☐	☐
Humidity	☐	☒	☐	☐
Noise	☐	☐	☐	☒
Fumes or gases	☐	☐	☐	☒
Hazards	☒	☐	☐	☐
Heights	☒	☐	☐	☐

27. Do your patient's symptoms affect the ability to concentrate or maintain attention?
_✓_Yes ____No

If yes, please circle the percentage of the workday that best represents how often these symptoms are severe enough to interfere with tasks:

5% 10% 15% (20%) 25% Over 25%

28. Do your patient's symptoms result in "good days" and "bad days"? _✓_Yes ____No

29. Would your patient's symptoms or treatment result in absences from work? _✓_Yes___No

If yes, please circle the amount that best represents how often your patient would miss work per month:

Less than one day One day (Two days) Three days More than three days

30. Does your patient take any medications that affect their ability to work? _✓_Yes ___No

If yes, please identify what activities your patient should avoid as a result of these medications or their side effects:

Ms. Capaldi takes muscle relaxants that can cause drowsiness and impair coordination.

Section C: Professional Observations

31. Has your patient cooperated with your treatment recommendations? _✓_Yes ____No

If not, please explain why your patient was unable to follow the recommended treatment:

_____

32. 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

33. Does your patient exaggerate symptoms? ___Yes _✓_No

34. Do you expect the patient's limitations to last at least one year? _✓_Yes ___No

35. On what date did these limitations begin?

I believe these limitations were present when I began treating Ms. Capaldi on July 11, 2021.

36. In your opinion, are your patient's limitations reasonably consistent with the objective medical evidence and physical evaluations as a whole? _✓_Yes ___No

Doctor's Name and Signature: Rose Mulholland, M.D. **Date:** October 14, 2024

Rose Mulholland, M.D.

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