Fibromyalgia Medical Assessment Form

Patient Name: _______________________________ **Date of Birth:** ___________________

Social Security #: _____________________________

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? _______________________________________

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

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

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
_____visual difficulties
_____diffuse muscle pain
_____leg cramps or restless legs
_____depression or anxiety
_____sore throat
_____muscle pain
_____unrefreshing sleep
_____chronic pain
_____irritable bowel (IBS)
_____carpal tunnel syndrome
_____vestibular dysfunction
_____menstrual disorders
_____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?_____________________________

9. Have these symptoms lasted for at least three months? _____Yes _____No

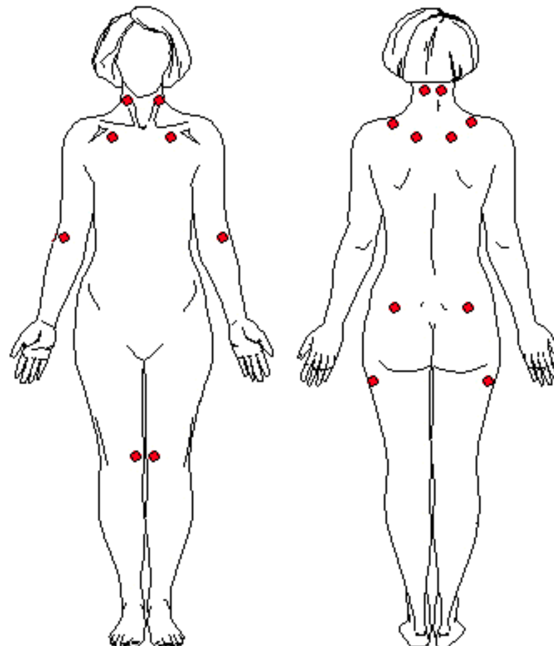
10. Are these symptoms related to emotional factors? _____Yes _____No

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 _____%)	_____tenderness	_____weight change
_____SLR (right at ____%)	_____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:

____

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?

____

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)?

____

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)?

____

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

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)?

____

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?

____

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?

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:

____

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? ____

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: _______________________________**Date:** _____________

Doctor's Address:

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