**PTSD: 12.15 TRAUMA & STRESS RELATED DISORDERS & MENTAL RESIDUAL FUNCTIONAL CAPACITY QUESTIONAIRE**

Patient: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**A.** **Nature frequency or length of contact**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

1. a. Summary of records or documents reviewed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ .

b. Assessment is: from: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ to: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. **Specify applicable diagnoses, (check appropriate category (ies) upon which the medical disposition is based**.

\_\_\_ 1. 12.02 Organic Mental Disorders, \_\_\_ 2. 12.03 Schizophrenic, Paranoid and Other Psychotic Disorder, \_\_\_ 3. 12.04 Affective Disorders, \_\_\_ 4. 12.05 Mental Retardation \_\_\_5. 12.06 Anxiety-Related Disorders, \_\_\_6. 12.07 Somatoform Disorders \_\_\_7. 12.08 Personality Disorders \_\_\_ 8. 12.09 Substance Addiction Disorders \_\_\_ 9. 12.10 Autism and Other Pervasive Developmental Disorders, \_\_\_ 10. 12.11 Neurodevelopmental disorders, \_\_\_ 11. 12.13 Eating Disorders, \_\_\_ 12. 12.15 Trauma and stressor – related disorders.

2. DSM-IV Multiaxial Evaluation:

Axis I: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis II: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis III: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis IV: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Axis V: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Current GAF: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Highest GAF this past Year: \_\_\_\_\_\_\_\_\_\_\_\_\_

3. Treatment and response: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

4. Describe side effects of medication w/ implications for working: \_\_\_ excessive sleep, \_\_\_ drowsiness, \_\_\_ fatigue, \_\_\_ decreased ability to concentrate: (other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

5. Describe *clinical findings* including results of IQ or mental status examination that demonstrate the severity of the claimant’s mental impairment and symptoms: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

6. Prognosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

7. Identify patient’s signs and symptoms:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

8. Patient: \_\_\_\_ does \_\_\_\_ does not : have a low IQ or reduced intellectual functioning.

a. The patient’s IQ can reasonably be estimated to be: \_\_\_\_ 69 and below \_\_\_\_ 70-84, \_\_\_ 85 and above. Please explain (w/re to specific test results if possible): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

9. Does the psychiatric condition exacerbate the claimant’s experience of pain or any other physical symptom/s? \_\_\_\_\_\_ Yes No If yes, please explain:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

10. The claimant’s mental condition \_\_\_\_ has \_\_\_\_ has not lasted or can it be expected to last at least 12 months.

11. The claimant’s impairments \_\_\_\_ are \_\_\_\_ are not reasonably consistent with the symptoms and functional limitations described in this Evaluation and clinical presentation.

13. Is the use of illicit drugs or alcohol a major contributing factor to patient’s mental impairment? \_\_\_\_\_ yes \_\_\_\_\_ no

**B. Criteria of the Listings**

The following is an indication as to what degree the following functional limitations (which are found in 12.00 and 12.15 and paragraph B of listings 12.02-12.04, 12.06-12.08 and 12.10 and paragraph D of 12.05) exist as a result of the individual’s mental disorder(s). The following definitions apply: “**Mild**” is defined as affecting the claimant between 1% to 5% of an 8 hour work-day, “**Moderate**” between 6% and 33%, “**Marked**”, between 34% and 66%, “**Extreme**”, 67% or more of an 8 hour day.

**12.15: For PTSD and/or Other Stress Related Disorders:**

1. a. Does the claimant have a history or symptoms of any or all of the following? Please check any and all that apply: \_\_\_ Exposure to actual or threatened death, serious injury, or violence; \_\_\_ Subsequent involuntary re-experiencing of the traumatic event (for example, intrusive memories, dreams, or flashbacks); \_\_\_ Avoidance of external reminders of the event; \_\_\_ Disturbance in mood and behavior; and \_\_\_ Increases in arousal and reactivity (for example, exaggerated startle response, sleep disturbance).

2. a. Does the claimant have a history or symptoms of extreme limitation of one, or marked limitation of two, of the following areas of mental functioning? Please check any and all that apply:

\_\_\_1. Ability to understand, remember, or apply information (see 12.00E1). \_\_ extreme limitation or \_\_ marked limitation

\_\_\_2. Ability to interact with others (see 12.00E2). \_\_ extreme limitation, or \_\_ marked limitation

\_\_\_3. Ability to concentrate, persist, or maintain pace (see 12.00E3). \_\_ extreme limitation, or \_\_\_marked limitation

\_\_\_4. Ability to adapt or manage oneself (see 12.00E4). \_\_ extreme limitation, or \_\_\_ marked limitation

3. a. Is the patient’s mental disorder in this listing category “serious and persistent;” that is, does he or she have a medically documented history of the existence of the disorder over a period of at least 2 years, and there is evidence of both: 1. Medical treatment, mental health therapy, psychosocial support(s), or a highly structured setting(s) that is ongoing and that diminishes the symptoms and signs of your mental disorder (see 12.00G2b); and 2. Marginal adjustment, that is, you have minimal capacity to adapt to changes in your environment or to demands that are not already part of your daily life (see 12.00G2c). \_\_\_ yes \_\_\_ no

4. a. For mental Impairments inclusive of 12.02-12.15 please provide your opinion as to the patient’s other mental limitations, including ADL (Activities of Daily Life)not already addressed above.

**FUNCTIONAL LIMITATION**  **DEGREE OF LIMITATION**

1. Restriction of ADL \_\_ None \_\_ Mild \_\_ Moderate \_\_ Marked\* \_\_ Extreme\* \_\_ Insufficient Evidence

2. Difficulties in Maintaining

Social Functioning: \_\_ None \_\_ Mild \_\_ Moderate \_\_ Marked\* \_\_ Extreme\* \_\_ Insufficient Evidence

3. Difficulties in Maintaining Concentration, Persistence or pace required to perform simple, routine repetitive

Tasks: \_\_ None \_\_ Mild \_\_ Moderate \_\_ Marked\* \_\_ Extreme\* \_\_ Insufficient Evidence

4. Repeated Episodes of Decompensation, each of 1 week or more resulting in patient’s inability to engage in

Full-time regular employment: \_\_ None \_\_ Mild \_\_ Moderate \_\_ Marked\* \_\_ Extreme\* \_\_ Insufficient Evidence

C. **Criteria of the Listings**

1. **Please complete this section & check the appropriate box as apply to the patient:**

Medically documented history of a chronic **organic mental** (12.02), **schizophrenic**, etc. (12.03), or **affective** **disorder** (12.04) of at least 2 years duration that has caused more than a minimal limitation of ability to do any basic work activity, with symptoms or signs currently attenuated by medication or psychosocial support, **and one of the following:**

\_\_\_ Repeated episodes of decompensation, each of extended duration \_\_\_ A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate

\_\_\_ Current history of 1 or more years inability to function outside a highly supportive living arrangement with an indication of continued need for such an arrangement

\_\_\_ Completeinability to function independently outside the area of one’s home

D. **Concentration and Attendance**

Regarding the following question, “**Rarely**” means 1%-5%, “**Occasionally**” means 6%-33%, “**Frequently**” means 34%-66%, “**Constantly**” means over 66% of an 8-hour working day. With those descriptions in mind, please answer the following question.

1. How often during a potential 8 hour work day would the patient be reasonably expected to experience psychiatric symptoms or the effects from prescribed medication that severe enough to interfere with attention and concentration needed to perform even simple routine repetitive tasks?

\_\_\_\_ **Never** \_\_\_\_ **Rarely** \_\_\_\_ **Occasionally** \_\_\_\_ **Frequently** \_\_\_\_ **Constantly**

1. On the average, it is reasonably anticipated to anticipate that the claimant’s psychiatric impairments, medications or treatment would cause the claimant to be absent from work as follows:

\_\_\_ **Never** \_\_\_ **1 day/month month** \_\_\_ **About 2 days/month** \_\_\_ **About 3 days/month**

\_\_\_ **About 4 days per month** \_\_\_ **More than 4 days per month**

1. Additional reasons not covered above why the claimant would have difficulty working at a regular job on a sustained basis not covered above: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.
2. Any additional comments: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5.** If applicable, t**he earliest date prior to the date of completion of this questionnaire that the description of**

**the symptoms and limitations in this questionnaire applies is:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date evaluation completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Physician’s Signature**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed or typed name of physician**

**(Or, attach business card here)**

**Date Form Completed: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**