

Psychiatric Assessment Form

**Patient:** \_\_\_\_\_

**SSN:** \_\_\_\_\_

Please answer each of the following questions about the patient. They concern the patient's claim of entitlement to disability benefits under the Social Security Act. Since this form will be used by the Social Security Administration in deciding if the patient is disabled, please make sure that it is legible and that every question is answered completely. If a question is not applicable to the patient, please so indicate.

1. Dates of treatment:

First \_\_\_\_\_ Last \_\_\_\_\_ Frequency \_\_\_\_\_

2. Diagnoses: \_\_\_\_\_

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

3. Provide results of recent mental status exam and results of any other tests given:

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

4. Describe patient's treatment, response and prognosis (include medications and side effects):

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

5. Have any of your patient's medical conditions lasted or can any be expected to last at least twelve months?  
\_\_\_\_ Yes \_\_\_\_ No. If yes, please specify: \_\_\_\_\_

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

6. Does the patient's condition result in difficulties understanding, remembering, or applying information? (**Note:** This area of functioning refers to the ability to learn, recall, and use information to perform work activities.)

Degree of Impairment: \* None \_\_\_ Mild \_\_\_ Moderate \_\_\_ Marked \_\_\_ Extreme \_\_\_

Please provide examples of any restriction of activities:

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7. Does the patient's condition result in difficulties interacting with others? (**Note:** This area of functioning refers to the ability to relate to and work with supervisors, co-workers, and the public.)

Degree of Impairment: \* None \_\_\_ Mild \_\_\_ Moderate \_\_\_ Marked \_\_\_ Extreme \_\_\_

Please provide examples of any difficulties in maintaining social functioning:

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8. Does the patient's condition cause deficiencies of concentration, persistence or pace? (**Note:** This area of functioning refers to the abilities to focus attention on work activities and stay on task at a sustained rate.)

Degree of Impairment: \* None \_\_\_ Mild \_\_\_ Moderate \_\_\_ Marked \_\_\_ Extreme \_\_\_

Please provide examples of any such deficiencies:

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9. Does the patient's condition cause difficulties adapting or managing oneself? (**Note:** This area of functioning refers to the ability to regulate emotions, control behavior, and maintain well-being in a work setting.)

Degree of Impairment: \* None \_\_\_ Mild \_\_\_ Moderate \_\_\_ Marked \_\_\_ Extreme \_\_\_

Please provide examples of any such deficiencies:

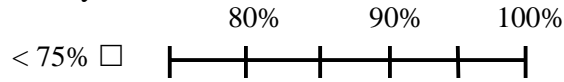
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\* Mild – slightly limited in ability to perform independently, appropriately, effectively, and on a sustained basis (**difficulty functioning less than 5% of the workday**): Moderate – fair ability to perform independently, appropriately, effectively, and on a sustained basis (**difficulty functioning 5-10% of the workday**): Marked – seriously limited ability to perform independently, appropriately, effectively, and on a sustained basis (**difficulty functioning 11-20% of the workday**): Extreme – unable to function independently, appropriately, effectively, and on a sustained basis (**difficulty functioning more than 20% of the workday**).

10. Please indicate below the percentage of an 8-hour work day that the patient can maintain attention/concentration satisfactorily:



11. Does the patient have a mental disorder of at least two years with symptoms or signs currently diminished by medication, psychotherapy, psychosocial support, or a highly structured setting<sup>1</sup>? Yes \_\_\_\_; No \_\_\_\_

If yes, has the disorder resulted in a minimal capacity to adapt to changes in environment or to increased mental or stress-related demands, such that a change in environment or increased demands lead to exacerbation of signs/symptoms and deterioration in functioning? Yes \_\_\_\_; No \_\_\_\_

12. Is the patient's condition likely to produce "good" days and "bad" days? Yes \_\_\_\_; No \_\_\_\_

If yes, please estimate, on average, how many days per month your patient is likely to be absent from work as a result of psychiatric symptoms.

- |                             |                                 |
|-----------------------------|---------------------------------|
| ____ Never                  | ____ About 3 days per month     |
| ____ About 1 day per month  | ____ About 4 days per month     |
| ____ About 2 days per month | ____ More than 4 days per month |

13. Additional comments:

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<sup>1</sup> Particularly in cases involving chronic mental disorders, overt symptomatology may be controlled or attenuated by psychosocial factors such as placement in a hospital, halfway house, board and care facility, or other environment that provides similar structure. **Highly structured settings may also be found in the home.**

Examples of a highly structured setting in the home may include: receiving help from family members or others who monitor the individual's daily activities and help them to function; participating in a sheltered, supported, or transitional work program; receiving assistance from a crisis response team, social workers, or community mental health workers who help to meet the individual's physical needs; living alone, but creating a highly structured environment by eliminating all but minimally necessary contact with the world outside the individual's living space.

**CHECKLIST OF FUNCTIONAL LIMITATIONS**

What follows is a list of common functional limitations associated with psychiatric impairment. Please check only those limitations that characterize your patient's illness. Please add any comments you wish in the spaces provided or on a separate sheet.

**1. Difficulties in Understanding, Remembering, or Applying Information**

Please check any area in which your patient has exhibited at least marked difficulty, either continuously or intermittently, in functioning independently, appropriately and/or effectively:

- Understanding and learning terms, instructions, and procedures
- Following one- or two-step oral instructions to carry out a task
- Describing work activity to someone else
- Asking and answering questions and providing explanations
- Recognizing a mistake and correcting it
- Identifying and solving problems
- Sequencing multi-step activities
- Using reason and judgment to make work-related decisions

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**2. Difficulties in Interacting With Others**

Please check any area in which your patient has exhibited at least marked difficulty, either continuously or intermittently, in functioning independently, appropriately and/or effectively:

- Cooperating with others
- Asking for help when needed
- Handling conflicts with others
- Stating own point of view
- Initiating or sustaining conversation
- Understanding and responding to social cues (physical, verbal, emotional)
- Responding to requests, suggestions, criticism, correction, and challenges
- Keeping social interactions free of excessive irritability, sensitivity, argumentativeness, or suspiciousness

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**3. Difficulties in Concentration, Persistence, or Pace**

Please check any area in which your patient has exhibited at least marked difficulty, either continuously or intermittently, in functioning independently, appropriately and/or effectively:

- Initiating and performing a task that they understand and know how to do
- Working at an appropriate and consistent pace
- Completing tasks in a timely manner
- Ignoring or avoiding distractions while working
- Changing activities or work settings without being disruptive
- Working close to or with others without interrupting or distracting them
- Sustaining an ordinary routine and regular attendance at work
- Working a full day without needing more than the allotted number or length of rest periods during the day.

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**4. Difficulties in Adapting or Managing Oneself**

Please check any area in which your patient has exhibited at least marked difficulty, either continuously or intermittently, in functioning independently, appropriately and/or effectively:

- Responding to demands
- Adapting to changes
- Managing psychologically based symptoms
- Distinguishing between acceptable and unacceptable work performance
- Setting realistic goals
- Making plans independently of others
- Maintaining personal hygiene and attire appropriate to a work setting
- Being aware of normal hazards and taking appropriate precautions

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**5. Basic Mental Demands of Any Work**

Please indicate below if your patient has experienced a substantial loss of the ability to meet any of the below basic mental demands of any work. An individual has a “substantial loss” of ability to perform a basic mental activity when he or she cannot perform the particular activity in regular, competitive employment but, at best, could do so only in a sheltered work setting where special considerations and attention are provided.

- \_\_\_ Remember work-like procedures.
- \_\_\_ Understand, remember, and carry out very short and simple instructions.
- \_\_\_ Maintain attention for extended periods of 2-hour segments.
- \_\_\_ Maintain regular attendance, and be punctual within customary tolerances.
- \_\_\_ Sustain an ordinary routine without special supervision.
- \_\_\_ Complete a normal workday/workweek without interruptions from psychologically based symptoms and perform at a consistent pace without an unreasonable number or length of rest periods.
- \_\_\_ Ask simple questions or request assistance.
- \_\_\_ Make simple work-related decisions.
- \_\_\_ Accept instructions and respond appropriately to criticism from supervisors.
- \_\_\_ Get along with coworkers or peers without (unduly) distracting them or exhibiting behavioral extremes.
- \_\_\_ Respond appropriately to changes in a (routine) work setting.

Comments: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Signature: \_\_\_\_\_  
Printed Name: \_\_\_\_\_  
Hospital: \_\_\_\_\_  
Address: \_\_\_\_\_  
\_\_\_\_\_  
Phone: \_\_\_\_\_

Date: \_\_\_\_\_

*If form is not completed by psychiatrist or psychologist, please have supervising psychiatrist or psychologist review and co-sign below.*

**Co-signed by:**  
Signature: \_\_\_\_\_  
Printed Name: \_\_\_\_\_

Date: \_\_\_\_\_  
Title: \_\_\_\_\_