Fibromyalgia/Chronic Myofascial Pain Syndrome Impact Assessment Form from

"The Fibromyalgia Advocate" by Devin J. Starlanyl

Adapted from Fibromyalgia Impact Assessment Form, 1991, Arthritis Care Resident 4:523 by

Mason, J., S.L. Silverman and A.L. Weaver et al.

To: Department of Health and Human Services Social Security

Re:_____ (name of patient)

_____(Social Security Number)

Please answer the following questions concerning your patient's impairments:

1. Nature, frequency and length of contact:_____

2. Does your patient meet American Rheumatological criteria for Fibromyalgia? ____Yes

____No

3. List any other diagnosed impairments:_____

_____

4. Prognosis:_____

5. Have your patient's impairments lasted or can they be expected to last at least 12 months?

___Yes ___No

6. Attach any recent reports which show patient impairments.

7. Check all of your patient's symptoms: _____Multiple tender points

_____Numbness and tingling _____Nonrestorative sleep _____ Chronic fatigue

_____Morning stiffness_____Allergies _____Subjective swelling _____Anxiety

_____Irritable Bowel Syndrome _____Panic Attacks _____Depression

_____Frequent severe headaches _____ Body_wide diffuse achiness

_____Sleep disorder _____Hypothyroidism _____ Dysmenorrhea or hysterectomy for same

_____ Dizziness _____Incoordination _____Chronic Fatigue Syndrome

_____Cognitive Impairment ___Temporomandibular Joint Dysfunction

_____Multiple Trigger Points _____ Muscle tightness

_____Myofascial Pain Syndrome _____Handwriting and keyboarding/fingering difficulties

_____Impairment of fine motor control_____Incoordination_____Sleep disorder

_____Frequent low back pain _____Visual percenption problems

_____Sensitivity to noise/light/odors/cold/heat/humidity

8. If your patient has pain:

a) identify the location of pain, including, where appropriate, an indication of right or left side or bilateral areas affected:

___Lumbosacral spine ___Cervical spine ___Thoracic spine ___Chest

____All of the above

Right Left Bilateral

___Shoulders ___ ___ ____

___Arms ___ ___ ____

___Hands/fingers ___ ___ ____

___Hips ___ ___ ____

___Legs ___ ___ ____

___knees/ankles/feet ___ ___ ____

___All of the above _____

b) Describe the nature, frequency, and severity of your patient's pain:_____

_____

c) Identify any factors that precipitate pain:

___Changing weather ____Fatigue ____Movement/overuse ____Stress ____Hormonal changes ____Cold ____Heat____Humidity ____Static position ___Allergy

Other: _____

9. Is your patient a malingerer? ___Yes ___No

10. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? ___Yes ___No

11. Are your patient's physical and emotional impairments reasonably consistent with symptoms and functional limitations described in this evaluation? ___Yes ___No.

12. How often is your patient's experience of pain sufficiently severe to interfere with attention and concentration?

___Never ___Seldom ___Often ___Frequently ___Constantly

13. To what degree is your patient limited in the ability to deal with work stress?

___No limitation ___Slight limitation ___Moderate limitation

___Marked limitation ___Severe limitation

14. Identify the side effects of any medication which may have implications for working, e.g. dizziness, drowsiness, stomach upset, etc:_____

_____

15. As a result of your patient's impairments, estimate your patients's functional limitations if your patient were placed in a competitive work situation:

a) How many city blocks can your patient walk without rest or severe pain?_____

Comment_____

b) Please circle the hours and/or minutes that your patient can <u>continually</u> sit and stand at one time:

Sit	Stand/walk	
___	___	Less than 2 hours
___	___	About 2 hours
___	___	About 4 hours

___ ___ At least 6 hours

d) Does your patient need to include periods of walking during an 8 hour day? ___Yes ___No

e) Does your patient need a job which permits shifting positions at will from sitting, standing or walking? ___Yes ___No

f) Will your patient sometimes need to lie down at unpredictable intervals during a work shift? ___Yes ___No

g) With prolonged sitting, should your patient's legs be elevated? ___Yes ___No

h) While engaged in occasional standing/walking, must your patient use a cane or other assistive device? ___Yes ___No

I) How many pounds <u>should</u> your patient carry in a competitive work situation?

	Never	Occasionally	Frequently
___Less than 10 lbs	___	____	___
___10 lbs	___	____	___
___20 lbs	___	____	___
___50 lbs	___	____	___

(In an average workday, "occasionally" means less than one third of a workday, "frequently" means between one_third to two_thirds of the workday.)

j) Does your patient have significant limitations in reaching, handling or fingering?___Yes___No

If yes, please indicate the percentage of time during a workday on a competitive job that your patient can use hands/fingers/arms for the following repetitive activities:

HANDS (grasp, turn, twist objects) FINGERS (fine manipulation)

Right _____% ____%

Left _____% ____%

ARMS (reaching_incl. overhead)

Right _____%

Left _____%

k) Does your patient have the ability to bend and twist at the waist? ____Not at all

____Occasionally ____Frequently

l) On the average, how often do you anticipate that your patient's impairments and treatments or treatment would cause the patient to be absent from work?

____Never _____Less than once a month

____About twice a month _____About three times a month

____About once a month _____More than three times a month

16. Please describe any other limitations that would affect this patient's ability to work at a regular job on a sustained basis:_____

_____

_____

Date:_____ Signed:_____

Print/type name:_____Phone_____

Address:_____fax_____