LINER LEGAL
DISABILITY LAWYERS

CHRONIC PAIN SYNDROME
MEDICAL SOURCE STATEMENT

Patient Name:_____ Date:_____
Provider Name / Specialty:_____

SECTION 1 — DIAGNOSIS, DURATION, AND LONGITUDINAL COURSE

Diagnosis (check all that apply):
☐ Chronic Pain Syndrome ☐ CRPS Type I ☐ CRPS Type II ☐ Other pain disorder: _____
Date symptoms first began: _____
Affected body region(s) or limb(s): _____
_____
Condition expected to last ≥ 12 months? ☐ Yes ☐ No
Overall course over time:
☐ Stable ☐ Gradually worsening ☐ Fluctuating / unpredictable

SECTION 2 — DISPROPORTIONATE PAIN AND AUTONOMIC / SENSORY FEATURES

Clinical features documented over time (check all that apply):
☐ Pain disproportionate to objective findings ☐ Allodynia ☐ Hyperalgesia ☐ Burning or electric pain
☐ Temperature asymmetry ☐ Color changes ☐ Edema ☐ Abnormal sweating ☐ Skin/nail changes
☐ Tremor ☐ Weakness ☐ Dystonia ☐ Decreased range of motion ☐ Autonomic instability
☐ Pain behavior observed during exams (if applicable): _____

SECTION 3 — PAIN SEVERITY, VARIABILITY, AND WORK SUSTAINABILITY

Due to pain, sensory disturbance, autonomic symptoms, or medication effects, the patient would be away from the work task (off-task and/or on unscheduled breaks) for approximately:
☐ 0% ☐ 10% ☐ 15% ☐ 20%+
This time away from task would be caused by (check all that apply):
☐ Pain spikes requiring cessation of activity
☐ Need to rest, reposition, or elevate
☐ Sensory intolerance or allodynia
☐ Autonomic symptoms
☐ Medication side effects
Likely absences per month:
☐ None ☐ 1 ☐ 2 ☐ 3+ ☐ Unable to sustain full-time attendance
Assistive device medically necessary?
☐ No ☐ Cane ☐ Crutch ☐ Walker ☐ Other: _____
Primary contributors to unreliable work functioning:
☐ Pain exacerbations ☐ Sensory disturbances ☐ Autonomic symptoms ☐ Medication side effects
☐ Limb dysfunction ☐ Fatigue ☐ Other: _____

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SECTION 4 — SITTING, STANDING, AND WALKING TOLERANCE

Indicate the total time the patient can perform each activity in an 8-hour workday.

ACTIVITY	0	1	2	3	4	5	6+
SITTING	☐	☐	☐	☐	☐	☐	☐
STANDING	☐	☐	☐	☐	☐	☐	☐
WALKING	☐	☐	☐	☐	☐	☐	☐

Needs to alternate positions at will? ☐ Yes ☐ No

Need to elevate affected limb(s)? ☐ Yes ☐ No If yes: Elevation height: _____ %

of workday: _____ %

Supporting findings (pain behaviors, guarding, swelling, autonomic changes, limited ROM): _____

_____

SECTION 5 — LIFTING, CARRYING, AND MANIPULATIVE CAPACITY

WEIGHT	NEVER (0%)	OCCASIONAL (≤1/3)	FREQUENT (1/3–2/3)	CONSTANT (2/3–100%)
<10 LBS	☐	☐	☐	☐
10 LBS	☐	☐	☐	☐
20 LBS	☐	☐	☐	☐
50 LBS	☐	☐	☐	☐

If upper extremity involved: _____

ACTIVITY	0	1	2	3	4	5	6+
SITTING	☐	☐	☐	☐	☐	☐	☐
STANDING	☐	☐	☐	☐	☐	☐	☐
WALKING	☐	☐	☐	☐	☐	☐	☐

Findings supporting these limitations: _____

SECTION 6 — CONSISTENCY

Do the limitations described above reflect what you have consistently observed and documented during treatment?

☐ Yes ☐ No ☐ Partially (explain): _____

Provider Signature: _____ Date: _____

Address / Phone: _____