LINER LEGAL
DISABILITY LAWYERS

GENERAL PHYSICAL IMPAIRMENTS MEDICAL SOURCE STATEMENT

Patient Name: _____ Date: _____

Provider Name / Specialty: _____

SECTION 1 — DIAGNOSIS AND DURATION

Primary Diagnoses: _____

Condition expected to last ≥ 12 months? ☐ Yes ☐ No

Primary symptoms (check all that apply): _____

☐ Pain ☐ Fatigue ☐ Weakness ☐ Dizziness ☐ Numbness/Tingling ☐ Joint stiffness ☐ Swelling

☐ Poor balance ☐ Coordination issues ☐ Headaches ☐ Vision problems ☐ Other: _____

SECTION 2 — SITTING, STANDING, AND WALKING TOLERANCE

For each activity below, circle or check the total number of hours your patient can perform this activity in an 8-hour day.

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

Needs to alternate positions at will? ☐ Yes ☐ No

Needs to walk periodically during the day? ☐ Yes ☐ No

Explain if applicable: _____

Supportive medical findings or symptoms for these limits (e.g., imaging, ROM loss, pain, weakness, edema):

_____

SECTION 3 — ASSISTIVE DEVICE (IF APPLICABLE)

Is a hand-held assistive device medically necessary? ☐ Yes ☐ No

Type:

☐ Cane ☐ Two canes ☐ Crutch ☐ Two crutches ☐ Walker ☐ Wheelchair/Scooter ☐ Other: _____

When required:

☐ All ambulation ☐ Long distances ☐ Prolonged standing ☐ Balance support ☐ Flare-ups only

Findings supporting medical necessity (e.g., imbalance, pain, weakness, neuropathy, joint instability, amputation): _____

SECTION 4 — LEG ELEVATION

Does your patient need to elevate one or both legs during the day? ☐ Yes ☐ No

If yes, how high? ☐ Footstool (6-12") ☐ Waist/chair level ☐ Above heart level

Approximate percentage of an 8-hour day: _____ %

What findings support this need (e.g., swelling, edema, circulation, pain)? _____

_____

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SECTION 5 — LIFTING, CARRYING, AND MANIPULATIVE FUNCTION

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

*****INSTRUCTIONS:** If limitation applies to the Left side, enter "L." If Right side, enter "R." If both, enter "B."***

ACTIVITY	NEVER (0%)	OCCASIONAL (≤1/3)	FREQUENT (1/3–2/3)	CONSTANT ((≤2/3)
HANDLING / GRASPING	☐L ☐R ☐B	☐L ☐R ☐B	☐L ☐R ☐B	☐L ☐R ☐B
FINGERING / FINE MANIPULATION	☐L ☐R ☐B	☐L ☐R ☐B	☐L ☐R ☐B	☐L ☐R ☐B
REACHING (FRONT / OVERHEAD)	☐L ☐R ☐B	☐L ☐R ☐B	☐L ☐R ☐B	☐L ☐R ☐B

Findings or exam results supporting these hand/arm limitations (e.g., grip strength, tremor, ROM, neuropathy): _____

SECTION 6 — ENDURANCE AND RELIABILITY

Unscheduled breaks? ☐Yes ☐No ☐ If yes, ≈_____ breaks/day × _____ min each

Expected off-task time: ☐≤5% ☐ 10% ☐15% ☐ ≤20%

Likely absences per month (if full-time): ☐ <1 ☐1 ☐2 ☐3 ☐ 4+

If any of the above apply, please explain the primary causes (pain, fatigue, medication effects, cognitive symptoms, etc.): _____

What medical findings or symptoms contribute to reduced endurance or concentration?_____

_____

SECTION 7 — CONSISTENCY

Do the limitations described above reflect what you have consistently observed and documented during your treatment of this patient? ☐Yes ☐No ☐Partially (explain): _____

Provider Signature: _____ Date: _____

Address / Phone: _____