LINER LEGAL
DISABILITY LAWYERS

LOWER EXTREMITY DISORDERS
MEDICAL SOURCE STATEMENT

Patient Name: _____ Date: _____

Provider Name / Specialty: _____ Treatment Frequency: _____

SECTION 1 — DIAGNOSIS AND DURATION

Primary Diagnoses (include affected joints/regions): _____

_____

Date of onset or surgery: _____ Condition expected to last ≥ 12 months? ☐ Yes ☐ No

Primary symptoms:

☐ Pain ☐ Weakness ☐ Numbness ☐ Fatigue ☐ Limited range of motion

☐ Instability ☐ Edema ☐ Spasms

SECTION 2 — STANDING, WALKING, AND POSTURAL TOLERANCE

Estimate the total time your patient can perform each activity in an 8-hour workday:

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

Typical walking distance without pain or rest:

☐ <25 ft ☐ 25–100 ft ☐ 100–200 ft ☐ >200 ft

Requires alternating sitting/standing at will? ☐ Yes ☐ No

Requires seated rest breaks? ☐ Yes ☐ No

If yes, frequency/duration: _____

Findings supporting these limits (e.g., antalgic gait, pain, fatigue, instability): _____

SECTION 3 — SITTING AND POSTURAL ENDURANCE

Total time able to sit in an 8-hour workday:

☐ 0–1 hr ☐ 2–3 hrs ☐ 4–5 hrs ☐ 6+ hrs

Needs to change position at will? ☐ Yes ☐ No

Needs to recline or elevate legs while seated? ☐ Yes ☐ No

If leg elevation is medically necessary, how much time per 8-hour day must the legs be elevated at or above waist level to control symptoms (pain, swelling, or circulation)?

☐ <1 hour ☐ 1–2 hours ☐ 3–4 hours ☐ Most of the day

If yes, describe: _____

Elevation height:

☐ Waist level ☐ Chest level ☐ Above heart

Frequency:

☐ Occasional ☐ Several times per hour ☐ Continuous requirement

Clinical findings supporting these needs (e.g., edema, pain relief, neuropathy): _____

Describe any specific positions or postures the patient must assume to relieve pain or pressure (e.g., shifting, leaning, semi-reclined, lying down): _____

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SECTION 4 — ASSISTIVE DEVICE USE

Does the patient require an assistive device for ambulation or balance? ☐ Yes ☐ No

If yes, indicate type and medical necessity:

☐ Cane ☐ Two canes ☐ Crutch(es) ☐ Walker

☐ Wheelchair ☐ Orthosis / Brace ☐ Other: _____

When required:

☐ All ambulation ☐ Long distances ☐ Uneven surfaces ☐ Balance support ☐ Flare-ups only

Can the patient carry objects while using the device? ☐ Yes ☐ No

Clinical findings supporting necessity (e.g., weakness, sensory loss, instability, post-surgical recovery):

_____

SECTION 5 — PAIN, FATIGUE, AND RELIABILITY

Pain intensity (average day):

☐ Mild ☐ Moderate ☐ Severe ☐ Very severe

Pain increases with:

☐ Standing ☐ Walking ☐ Sitting ☐ Bending

☐ Weight-bearing ☐ Weather changes

Needs unscheduled breaks? ☐ Yes ☐ No ☐ If yes, _____ breaks/day × _____ minutes each _____

Expected off-task time:

☐ <5% ☐ 10% ☐ 15% ☐ 20% ☐ 25%+

Likely absences per month (if full-time):

☐ <1 ☐ 1 ☐ 2 ☐ 3 ☐ 4+

Findings supporting these limitations (e.g., muscle spasm, nerve compression, documented fatigue):

_____

Do pain medications, injections, or other treatments cause side effects (e.g., sedation, dizziness, slowed cognition) that would interfere with sustained work activity? ☐ Yes ☐ No

If yes, describe: _____

SECTION 6 — FUNCTIONAL SUMMARY

Do the limitations described above prevent the patient from sustaining even sedentary work (sitting most of the day with brief standing/walking)? ☐ Yes ☐ No ☐ Uncertain

If "Yes," indicate primary causes:

☐ Pain intensity ☐ Fatigue ☐ Postural intolerance ☐ Need for leg elevation

☐ Ambulation limitations ☐ Instability / fall risk ☐ Other: _____

Are these limitations consistent with your clinical observations and diagnostic findings?

☐ Yes ☐ No ☐ Partially (explain): _____

Provider Signature: _____ Date: _____

Address / Phone: _____