LINER LEGAL
DISABILITY LAWYERS

SPINAL DISORDERS
MEDICAL SOURCE STATEMENT

Patient Name: _____ Date: _____

Provider Name / Specialty: _____

Treatment Frequency: _____

SECTION 1 — DIAGNOSIS AND DURATION

Primary Diagnoses (include affected region and relevant findings): _____

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

Primary symptoms:

☐ Pain ☐ Numbness ☐ Weakness ☐ Spasm ☐ Radiating pain

☐ Limited motion ☐ Balance problems ☐ Fatigue

SECTION 2 — SITTING, STANDING, AND WALKING 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	☐	☐	☐	☐	☐	☐	☐

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

Needs seated rest breaks? ☐ Yes ☐ No If yes, frequency/duration: _____

Needs to recline or elevate legs to relieve pain or swelling? ☐ Yes ☐ No

If leg elevation is medically necessary, please describe: _____

Height (e.g., "waist level," "chest level," "above heart"): _____

Duration per 8-hour workday: _____

Findings supporting these limits (e.g., spasm, nerve compression, pain with movement): _____

_____

SECTION 3 — LIFTING AND CARRYING FUNCTION

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

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SECTION 4 — UPPER EXTREMITY FUNCTION (IF CERVICAL OR THORACIC INVOLVEMENT)

Please indicate whether each limitation affects the Left (L), Right (R), or Both (B) arms/hands, and how often the activity can be performed in a typical workday.

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

SECTION 5 — PAIN, FATIGUE, AND RELIEF POSTURES

Pain increases with:

☐ Sitting ☐ Standing ☐ Walking ☐ Bending ☐ Lifting ☐ Neck motion ☐ Repetition

Describe positions or postures required to relieve pain (e.g., shifting, semi-reclined, lying down): _____

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+

Do medications or injections cause side effects (e.g., sedation, dizziness, slowed cognition)? ☐ Yes ☐ No

If yes, describe: _____

SECTION 6 — NEUROLOGICAL FINDINGS

☐ Muscle weakness ☐ Numbness ☐ Loss of reflexes ☐ Positive straight-leg raise

☐ Gait abnormality ☐ Decreased coordination ☐ Spinal tenderness

Objective findings supporting limitations (e.g., EMG, imaging, physical exam): _____

SECTION 7 — FUNCTIONAL SUMMARY

Do the limitations described above prevent this 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 ☐ Nerve compression ☐ Upper extremity dysfunction ☐ Postural

☐ intolerance ☐ Need for breaks or position changes ☐ Other: _____

Are these limitations consistent with your clinical observations and diagnostic findings? ☐ Yes ☐ No

☐ Partially (explain): _____

SUPPORTING CLINICAL FINDINGS

Briefly describe the key clinical or diagnostic findings that support the limitations checked above (e.g., imaging, exam findings, nerve studies, pain behaviors): _____

Provider Signature: _____ Date: _____

Address / Phone: _____