LINER LEGAL
DISABILITY LAWYERS

TRAUMATIC BRAIN INJURY (TBI)
MEDICAL SOURCE STATEMENT

Patient Name: _____ Date: _____

Provider Name / Specialty: _____

SECTION 1 — DIAGNOSIS, DATE OF INJURY, AND DURATION

Traumatic brain injury diagnosis supported by medical records and imaging? ☐ Yes ☐ No

Date of traumatic brain injury: _____

Overall course since injury:

☐ Improved but residual deficits persist
☐ Stable residual deficits
☐ Fluctuating / episodic worsening
☐ Progressive decline

SECTION 2 — COGNITIVE, BEHAVIORAL, AND NEUROPSYCHOLOGICAL RESIDUALS

Documented post-injury cognitive or behavioral deficits (check all that apply):

☐ Memory impairment
☐ Slowed processing speed
☐ Reduced attention/concentration
☐ Executive dysfunction
☐ Impaired judgment
☐ Reduced insight
☐ Difficulty learning new tasks
☐ Behavioral disinhibition
☐ Irritability or emotional lability
☐ Reduced stress tolerance
☐ Mental fatigue

Supporting findings (neuropsychological testing, clinical observation, collateral reports): _____

SECTION 3 — COMMUNICATION AND SOCIAL INTERACTION LIMITATIONS

Documented communication or interaction deficits (if present):

☐ Aphasia
☐ Word-finding difficulty
☐ Dysarthria
☐ Difficulty understanding instructions
☐ Difficulty expressing needs
☐ Reduced ability to interact appropriately with others

Supporting findings (speech therapy notes, clinical observation): _____

SECTION 4 — FATIGUE, VARIABILITY, AND WORK SUSTAINABILITY

Typical baseline mental or physical endurance level:

☐ Mild
☐ Moderate
☐ Severe
☐ Very severe / disabling

Symptom variability: _____

How often do cognitive, behavioral, or physical symptoms unpredictably worsen?

☐ Daily
☐ Several times per week
☐ Weekly
☐ Monthly
☐ Unpredictable

When symptoms worsen, the patient is unable to reliably (check all that apply):

☐ Maintain attention or pace
☐ Follow simple instructions
☐ Sustain mental activity
☐ Regulate behavior or emotions
☐ Complete tasks on schedule
☐ Adapt to changes or stress
☐ Leave home

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Due to residual cognitive, behavioral, or neurologic symptoms, the patient would be away from the work task (off-task and/or on unscheduled breaks) for approximately:

☐0% ☐10% ☐15% ☐20%+

Likely absences per month due to residual symptoms:

☐None ☐1 ☐2 ☐3+

SECTION 5 — MOTOR, BALANCE, AND COORDINATION LIMITATIONS (IF APPLICABLE)

Documented physical residuals from TBI (check all that apply):

☐Weakness ☐Spasticity ☐Abnormal gait ☐Balance impairment

☐Coordination deficits ☐Tremor ☐Sensory loss ☐Headaches

Supporting findings (exam findings, therapy records): _____

SECTION 6 — SITTING, STANDING, AND WALKING TOLERANCE (IF APPLICABLE)

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

Supporting findings (fatigue-related decline, balance issues, safety concerns): _____

SECTION 7 — UPPER EXTREMITY USE AND MANIPULATIVE RELIABILITY (IF APPLICABLE)

Frequency of use limitations:

ACTIVITY	NEVER (0%)	OCCASIONAL (≤1/3)	FREQUENT (1/3–2/3)	CONSTANT (2/3 - 100%)
HANDLING	☐	☐	☐	☐
FINGERING	☐	☐	☐	☐
REACHING	☐	☐	☐	☐

SECTION 8 — LIFTING, CARRYING, AND PHYSICAL ENDURANCE (IF APPLICABLE)

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

Physical or cognitive fatigue significantly limits sustained exertion even at low levels? ☐Yes ☐No

SECTION 9 — CONSISTENCY

Do the limitations described above reflect what you have consistently observed and documented since the traumatic brain injury, including longitudinal records and collateral reports?

☐Yes ☐No ☐Partially (explain): _____

Provider Signature: _____ Date: _____

Address / Phone: _____