LINER LEGAL
DISABILITY LAWYERS

UPPER EXTREMITY / CERVICAL 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 ☐ Numbness ☐ Tingling ☐ Weakness ☐ Limited motion

☐ Spasm ☐ Loss of dexterity ☐ Fatigue

SECTION 2 — USE OF ARMS AND HANDS DURING A TYPICAL WORKDAY

ACTIVITY AFFECTED SIDE (L/R/B)	NEVER (0%)	OCCASIONAL (≤1/3)	FREQUENT (1/3–2/3)	CONSTANT (2/3 - 100%)
REACHING (FRONT AND LATERAL)	☐	☐	☐	☐
REACHING (OVERHEAD)	☐	☐	☐	☐
HANDLING / GRASPING (GROSS MANIPULATION)	☐	☐	☐	☐
FINGERING / FINE MANIPULATION	☐	☐	☐	☐
FEELING (TACTILE SENSATION)	☐	☐	☐	☐

Does repetitive motion exacerbate pain, weakness, or paresthesia? ☐ Yes ☐ No

If yes, describe: _____

Can the patient sustain fine motor activity (typing, sorting, gripping) for more than 10–15 minutes continuously? ☐ Yes ☐ No

If no, describe: _____

SECTION 3 — PRECISION, ACCURACY, AND COORDINATION

Does the patient have difficulty performing tasks requiring fine precision or hand-eye coordination (e.g., typing, writing, buttoning, assembling small objects)? ☐ Yes ☐ No

If yes, describe: _____

If yes, does inaccuracy occur due to:

☐ Tremor ☐ Numbness ☐ Weakness ☐ Other: _____

Can the patient perform fine or manipulative tasks at a normal speed and accuracy for more than brief periods? ☐ Yes ☐ No

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If no, describe typical duration or observed slowing: _____
Is the patient prone to dropping objects or losing grip on tools, utensils, or work materials? ☐ Yes ☐ No
If yes, describe frequency or severity: _____

SECTION 4 — PAIN, FATIGUE, AND POSTURAL NEEDS

Pain increases with:

☐ Repetition ☐ Overhead reaching ☐ Lifting ☐ Neck movement ☐ Fine manipulation

Describe any positions or postures required for pain relief (e.g., arm support, neck flexion, resting wrist):

_____

Needs unscheduled breaks to rest upper extremities? ☐ 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+

SECTION 5 — FUNCTIONAL SUMMARY AND NEUROLOGICAL FINDINGS

☐ Decreased grip strength ☐ Reduced range of motion ☐ Atrophy
☐ Positive Tinel's or Phalen's ☐ Nerve root impingement ☐ Tremor ☐ Sensory loss

Describe key clinical or diagnostic findings supporting these limitations (e.g., EMG, MRI, grip testing, physical exam): _____

Do the limitations described above prevent the patient from performing sustained full-time work requiring repetitive use of the hands or arms (reaching, handling, fingering, or feeling)? ☐ Yes ☐ No ☐ Uncertain

If "Yes," indicate the primary reasons:

☐ Pain ☐ Weakness ☐ Nerve compression ☐ Loss of dexterity ☐ Need for rest periods
☐ Fatigue ☐ Other:

Are these limitations consistent with your clinical observations and diagnostic findings? ☐ Yes ☐ No
Partially (explain): _____

Provider Signature: _____ Date: _____
Address / Phone: _____