

Ohio DDD Internal Medicine

Consultative Examination Guidelines

Part V: Neurological Consultative Examination Guidelines

General Examination/Report Requirements

Introduction and Required Components

Make sure the report - through its thoroughness and the presentation and interpretation of evidence - demonstrates that a genuine effort has been made to identify all diagnoses and probable diagnoses, as well as formulate a carefully thought-out assessment of current functional status ("Medical Source Statement").

Make sure that the report documents the positive elements of the medical history and physical examination, as well as the negative elements. This is crucial because DDD cannot accept that an element of the history or physical examination was negative or normal unless it was explicitly stated to be negative or normal.

Make sure that all of the following requirements are met and documented in the report narrative using appropriate headings:

- A. Identify the Claimant
- B. List All Chief Complaints
- C. Elaborate on Each Complaint in the History of Present Illness
- D. Document All Elements of Medical History
- E. Describe Claimant's Usual Daily Activities and Ability to Perform Activities of Daily Living
- F. List All Medications
- G. Document the Family History
- H. Document the Social History
- I. List Results of the Review of Systems
- J. Measure Vital Signs
- K. Measure Visual Acuities
- L. Describe Claimant's General Appearance and Presentation
- M. Examine the Head, Eyes, Ears and Throat
- N. Examine the Neck
- O. Observe and Examine the Back and Spine
- P. Examine the Extremities and Measure Ranges of Motion
- Q. Perform a Neurological Examination
- R. Examine the Skin
- S. Review Medical Records from DDD
- T. Review Results of X-Rays or Other Tests You Performed in Your Office
- U. List All of Your Diagnostic Impressions
- V. Provide a Functional Statement ("Medical Source Statement")
- W. Enter Manual Muscle Test Results in

- Neuromuscular Data Sheet
- X. Enter the Range of Motion Test Results in Neuromuscular Data Sheet
- Y. 1151 Form
- Z. Proofread
- AA. Signature

What If a Report is Inadequate?

If a report contains errors, DDD will need you to prepare an addendum that contains corrections or clarifying information. *Note: You are not paid for drafting addenda.*

If a report is missing important historical information or elements of the physical examination, DDD will need you to prepare an addendum and, in some cases, will require you to reexamine the claimant in your office at your own expense.

DDD understands that in some cases a claimant may be uncooperative. Document this in your report.

Thoroughness and Time Spent During History and Physical

DDD does not want you to rush through these important examinations, which are distinct from your regular examinations in the course of medical practice. Sometimes a consultative examination is the only medical evidence DDD will receive, making it vital to the determination process.

You need not create a therapeutic relationship during a consultative examination, but do allow enough time so that some degree of rapport can be developed between examiner and examinee. Allow ample time for the claimant to state all of his or her complaints and symptoms and to answer all of the questions with minimal interruptions from the examiner. This may take about an hour, but SSA requires that the history and physical (not including the writing and dictating of the report) must take 30 minutes or more.

Avoid excessively brief examinations. Important elements of the history or physical could be omitted during a cursory history and physical, which could result in the consultant having to complete a request for a clarifying addendum or even reexamine the claimant at the consultant's own expense. SSA requires that all claimant complaints be investigated, and one of the most common complaints is that an examination was too brief.

Who Is Permitted to Perform Various Parts of the Examination?

DDD realizes that a physician is not needed to weigh, measure height, take blood pressure and pulse, or even measure visual acuity; however, SSA has published criteria that specify who can and who cannot do various aspects of the history, physical examination and ancillary testing.

The Green Book states: "The medical source chosen may use support staff to help perform the consultative examination. Any such support staff (e.g., X-ray technician, nurse, etc.) must meet appropriate licensing or certification requirements of the State."

DDD has no problem with some elements of the examination or testing being performed by appropriate support staff, which would include licensed and certified physician extenders like physician assistants and nurse practitioners. Similarly, a licensed and certified physical therapist or occupational therapist could measure ranges of motion and a licensed and certified respiratory therapist could conduct spirometry or other pulmonary function testing. Except for these substitutions, DDD expects that the physician personally perform all of the following:

- Take the history
- Examine the claimant
- Conduct ancillary testing

Some physicians use patient-completed questionnaires. If you do use one or more of these forms, you must still go through the claimant's chief complaints, history of present illness, past medical history, family history, social history, and review of systems using spoken questions that elicit spoken responses (unless the claimant cannot speak). DDD cannot assume that all claimants can read or comprehend the printed questions on a questionnaire. The entire, or vast majority of the consultative examination must use face-to-face verbal interaction.

Professionalism and Complaints

DDD follows a formal procedure when a complaint is received. Common complaints in the past, aside from allegations of an excessively brief examination, have included that the consultant:

- Was rude
- Asked questions too quickly
- Did not give the claimant enough time to answer the questions
- Was rough when testing range of motion
- Had a poor bedside manner
- Told the claimant he/she was not disabled
- Told the claimant to go get a job

If any complaint is received, DDD will write you, request a written response to the claimant's allegations and evaluate your response.

If a consultant receives multiple complaints, DDD will investigate and may cease to do business with that consultant.

You must be sincere and professional in all of your encounters with claimants.

Routine Review of Consultative Examination Quality

A statistical sample of reports is reviewed weekly by DDD's Chief Medical Consultant. When a report is found to be unsatisfactory, a letter is sent to the consultant, who must then submit a clarifying addendum. DDD monitors reports that deviate from SSA and DDD standards; however, most consultants regularly meet or exceed examination/report standards. When DDD does find poor quality reports, with no improvement in response to constructive criticism, the agency may cease to do business with a consultant.

Definite and Probable Diagnoses: Dealing with Uncertainty

The primary reason DDD needs your services through a consultative examination is that the agency has received little or no medical evidence from a claimant's treating sources. This is usually because the treating sources have not responded to medical records requests or the claimant does not have a treating source. As a result, when you see a claimant, you may not have other medical data that would assist you in definitively diagnosing any impairments or conditions that he or she may have.

Because of the lack of medical testing and other data, you may not have enough information to make one or more definitive diagnoses on the basis of a one-time history and physical examination. It is acceptable to mention probable diagnoses. For example, in a claimant with a history of a sudden right hemiparesis and aphasia a few months prior with the presence of significant residual deficits and a history of vascular disease elsewhere, it is recommended that you list "probable left brain stroke" in your list of diagnoses even though you do not have a CT or MRI report.

Voucher Information

Read all of the voucher information so that you complete what is requested. On some occasions, there are special instructions about specific elements of the history or physical upon which DDD would like you to focus and comment. Common special instructions and questions include:

- Can the claimant hear conversational speech?
- Does the claimant have brawny edema and if so, how far up the leg does it extend?
- Has the claimant's foot ulcer healed?

Conducting Tests that Have Not Been Ordered

In the past, some consultants - on their own - have decided that an unorderd test would be helpful and have gone on to perform the test. **This must not be done.** Payment will not be rendered for testing that is not preapproved and ordered on the voucher.

How to Add a Test

If you think it would be beneficial to add a test, such as a lumbosacral X-ray, call DDD to discuss the suggestion. Sometimes, the agency will approve the added test. If DDD approves the test, you will be paid for it, but **only** if you follow proper procedures and get approval in advance.

Non-English-Speaking Claimants

For non-English speaking claimants, the history must be obtained from family members present during the exam or from an interpreter contracted by the DDD. Report communication difficulties whether due to:

- Language barrier
- Difficulty hearing
- Difficulty speaking
- Difficulty seeing
- Cognitive impairment
- Mental illness
- Other

Specific Examination/Report Requirements

Identify the Claimant

Compare the claimant's countenance with a valid photo identification card.

List All Chief Complaints

- Give claimant ample time to name complaints.
- Instead of asking, "Why can't you work?" be general and ask, "What sorts of physical problems and symptoms do you have?"
- Report from whom you obtained the medical history.
- Record whether you believe the claimant or other informant was reliable in presenting the history.

Elaborate on Each Complaint in the History of Present Illness

- Elaborate fully on each symptom and specific illness stated as a chief complaint. Elaboration is not required on any psychologic, emotional or mental allegations.
- Record when each major symptom and each specific illness began.
- Explain how each specific illness was diagnosed.
- Describe the severity of each symptom and specific illness at onset and how the severity has changed or progressed.
- Document the treatments or surgeries or procedures that have been done and how successful they have been.
- Report illnesses with episodic events such as seizures, syncope, and "spells," in a special way:
 - » List the dates of all events (if possible).
 - » List the frequency of events, such as how many seizures per week or month.
 - » Report whether the claimant was treated in the emergency department or admitted to the hospital.
 - » Describe the treatments.
 - » State what precipitated the events (if known).
 - » List any reason for the events, such as low anticonvulsant blood levels.
- Report symptoms or specific illnesses associated with pain in a special way:
 - » Describe where the pain is located (describe all areas if multiple sites).
 - » State whether there is a known (or probable) underlying disease or disorder to which to attribute the pain.
 - » Describe the character of the pain.
 - » Record when the pain first occurred and how it has changed or progressed.
 - » List what makes the pain worse.
 - » List what makes the pain better.
 - » Describe the treatments, surgeries, or procedures that have been done and how successful they have been.

- For an example of specific questions for a common chief complaints, *see Example of Key Questions for Common Chief Complaints (see Appendix A)*.

Document All Elements of Medical History

- List significant traumas
- List surgeries and significant procedures
- List recent transfusions
- List hospitalizations
- List all neurological diagnoses
- List all medical diagnoses
- List all psychiatric diagnoses

Describe Claimant's Usual Daily Activities and Abilities to Perform Activities of Daily Living

List All Medications

Document Family History

If present, list family histories of:

- Muscular dystrophy
- Stroke
- Subarachnoid hemorrhages
- Brain tumors
- Parkinson's disease
- Huntington's disease
- Multiple sclerosis
- Optic neuritis
- Ataxia
- Neuropathy
- Osteoarthritis of the spine
- Dementia
- Amyotrophic lateral sclerosis
- Transverse myelitis
- Movement disorders
- Myasthenia gravis
- Congenital deafness or blindness
- Other neurological or neuromuscular conditions or syndromes

Document Social History

List whether the following have been used and the extent of use (i.e., pack years, etc.):

- Tobacco (smoking)
- Tobacco (smokeless)
- Alcohol
- Illicit drugs

List Results of Review of Systems (focusing on the musculoskeletal and nervous systems, including episodic symptoms such as seizures)

- Record the positive results.
- Record the negative results. DDD cannot assume a symptom was absent if not explicitly stated.

Measure Vital Signs

Report each of the following:

- Measured height without shoes
- Measured weight without shoes
- Sitting blood pressure
- Sitting pulse
- Sitting respiratory rate
- Oral temperature if you believe the claimant is febrile
- If severe kyphoscoliosis is present
- Measured arm span from finger tips to finger tips

It is helpful, but not required, that you calculate and record body mass index (BMI). *Note: Morbid obesity (BMI 40+) is a medically-determinable impairment per SSA.*

Measure Visual Acuities

- Measure in all claimants.
- Measure each eye separately with the claimant wearing his or her glasses if applicable. Note if a claimant wears glasses but did not bring them to the exam.
- Describe acuities of worse than 20/200 by the standard qualitative measures:
 - » No light perception
 - » Light perception
 - » Hand motion
 - » Counts fingers (at specified distances)
- Record any diagnosed eye diseases under "History of Present Illnesses" if visual impairment is a chief complaint, or under "Past Medical History," if visual impairment is not a chief complaint.

Describe Claimant's General Appearance and Presentation

- Describe the salient features of your first impression of the claimant in detail.
- Especially important are observations of:
 - » Mobility
 - » Dexterity and handedness
 - » Acute illness
 - » Chronic illness
 - » Morbid obesity
 - » Malnutrition
 - » Ability to walk (*see also Examine the Extremities and Measure Ranges of Motion*)
 - » Ability to dress and undress
 - » Ability to climb on to and off of the examination table
 - » Ability to squat and get up from a chair
 - » Involuntary movements
 - » Congenital deformities or syndromic features

Examine the Head, Eyes, Ears and Throat

- Note head size and shape and the presence of any abnormalities that suggest neurologic syndromes.
- Check for the red reflex and note the presence of cataracts, if present.
- Note conjunctival pallor, if present.
- Note the color of the sclera.
- Assess pupil reactivity.
- Test extraocular muscle function and note the presence of strabismus, if present.
- Complete funduscopic examination and describe any abnormalities, especially of the optic disk, macula, blood vessels, and periphery.
- Assess ear canal patency and tympanic membrane integrity and appearance.

Examine the Neck

- Check especially for carotid bruits.

Examine the Back and Spine

- Record any of these findings, if present:
 - » Kyphosis
 - » Scoliosis
 - » Paraspinal muscle spasm
 - » Paraspinal tenderness
 - » Sacroiliac joint tenderness
 - » Vertebral tenderness
 - » Listing of the lower back that makes one hip appear higher than the other
 - » Surgical scars

- If myofascial pain or fibromyalgia is alleged, palpate the tender point locations as specified by the American College of Rheumatology. Also, test for allodynia.
- Measure spine ranges of motion and record these measurement on the *Range of Motion Form (see Part II - Appendix B)*.
- Perform the straight leg raising test in both the sitting and supine positions and record whether there is:
 - » No pain
 - » Pain in the back
 - » Pain that radiated down the leg to the foot
 - » Pain in the back plus pain that radiated down the leg to the foot.

Examine Extremities and Measure Range of Motion

Focus the extremity on exam on eight major areas:

1. Measure the active and passive ranges of motion of all major joints as listed on the *Range of Motion Form (see Part II - Appendix B)*.
 - » Preferably use a goniometer for these measurements.
 - » Record these measurements on the *Range of Motion Form (see Part II - Appendix B)*.
 - » You do not need to detail all these measurement in the narrative; in fact, this makes the narrative needlessly long and tedious.
2. Observe and palpate painful joints, joints with decreased range of motion, and joints that appear grossly abnormal.
 - » Record any of the following joint findings, if present:
 - *Bony enlargement*
 - *Swelling or effusion*
 - *Synovial thickening*
 - *Warmth*
 - *Erythema*
 - *Tenderness*
 - *Pain with range of motion maneuvers*
 - *Deformities, such as ulnar deviation, or varus or valgus deformities of the knee*
 - *Contractures*
 - *Ligamentous laxity*
 - *Crepitus*

3. Observe gait in detail.

- » A detailed gait description is needed if the claimant:
 - *Has a visible limp or other abnormality of gait*
 - *Alleges trouble walking or maintaining balance*
 - *Has had a stroke or has another neuromuscular condition*
 - *Has pain, or decreased range of motion or an abnormality on examination of the foot/ankle, knee, hip or spine*
 - *Has weakness*
 - *Has sensory loss*
 - *Has ataxia or imbalance or incoordination*
- » A detailed gait description includes all of the following:
 - *Describe exactly what you observe when the claimant walks or attempts to walk. (see Part II - Appendix C for select abnormalities of gait.)*
 - *If the claimant uses a hand-held assistive device, if safe to do so, observe the claimant attempting to walk without the assistive device.*
 - *If the claimant uses a hand-held assistive device, decide whether it is necessary (obligatory) to allow ambulation in each of these circumstances:*
 - *Short distances on level surfaces*
 - *Long distances on level surfaces*
 - *Short distances on uneven surfaces*
 - *Long distances on uneven surfaces*
 - *Is the claimant a fall risk?*
 - *Attempt to estimate how many total hours (per 8 hour workday) the claimant can be in the upright position ("on his or her feet") either standing or walking (combined).*

4. Observe hand function in detail.

- » Using the *Range of Motion section of the Neuromuscular Data Sheet (Part II - Appendix B)*, record whether the claimant can:
 - *Open a door*
 - *Open a jar*
 - *Pick up keys*
 - *Pick up a coin*
 - *Write*
 - *Button*
 - *Unbutton*
 - *Zip*
 - *Unzip*

- » Using the *Manual Muscle Testing section of the Neuromuscular Data Sheet (Part II - Appendix B)*, describe claimant's ability to:
 - *Grasp (grabbing, as in a hand shake)*
 - *Manipulate (handle)*
 - *Pinch (between the thumb and index finger)*
 - *Finely manipulate (rely on finger functioning as in typing).*

5. Observe limb bulk and symmetry for atrophy or differences in the sizes of the opposite extremities.

- » Using the *Range of Motion section of the Neuromuscular Data Sheet (Part II - Appendix B)*, record measurements of the circumference of the forearms, arms, thighs and legs if there is any suspicion of atrophy or asymmetry due to swelling/edema.

6. Observe the feet and ankles without socks and shoes.

- » Record any of these findings, if present:
 - *Charcot foot*
 - *Neuropathic foot ulcers*
 - *Foot drop*
 - *Other neurological findings in the feet.*

7. Palpate peripheral pulses and look for signs of arterial insufficiency.

- » Grade pulses "not palpable" through 4+.
- » Remark if there is:
 - *Dependent rubor*
 - *Blanching on elevation of the leg*
 - *Skin atrophy*
 - *Loss of hair growth*

8. In amputations, observe the status of the stump.

- » If a claimant has a prosthesis, describe ambulation with it in place.
- » If a claimant does not have a prosthesis, observe and describe ambulation (if this can be safely done).

Perform a Neurological Examination

Perform a comprehensive neurological examination that must include each of the following 13 elements, though some elements have been described in other sections:

1. Describe general appearance and presentation (*see Describe Claimant's General Appearance and Presentation*)
2. Measure visual acuities (*see Measure Visual Acuities*)
3. Assess all cranial nerves (*see Examination of the Head, Eyes, Ears and Throat*)
 - » Assess visual fields by confrontation.
 - » Assess of conversational speech can be heard and understood.
 - » Comment on whether speech can be heard and sustained and is intelligible.
 - » Comment on whether there is stuttering or involuntary vocalizations.
 - » Comment on whether there is expressive, receptive, or mixed aphasia.
4. Observe gait in detail (*see Examine the Extremities and Ranges of Motion*)
5. Describe hand function in detail (*see Examine the Extremities and Ranges of Motion*)
6. Examine motor strength in all major muscle groups graded as 0 through 5, where 5 is normal. Record this on the *Manual Muscle Testing Form* (*see Appendix D*, which in addition, describes the five muscle strength grades).
 - » Attempt to elicit Babinski's sign.
 - » Conduct motor strength proxy tests including:
 - *Ability to rise from the seated position without using hands*
 - *Ability to mount the examination table*
 - *Ability to dismount the examination table*
 - *Toe-walking*
 - *Heel-walking*
 - *Hopping*
 - *Pronator drift*
 - » Note whether you can demonstrate muscle fatigue on exam with repetitive muscle contraction/use as this is sometimes a limiting factor in neurological and neuromuscular conditions.
7. Record any of the following findings, if present:
 - *Clonus*
 - *Increased muscle tone*
 - *Muscle hypertrophy*
 - *Decreased muscle tone*
 - *Spasticity*
 - *Flaccidity*
 - *"Cog-wheeling" rigidity*
 - *"Lead-pipe" rigidity*
 - *Lack of arm swing with walking*
 - *Slowness of movement (bradykinesia)*
7. Observe any muscular atrophy and measure the circumference of the forearms, arms, thighs, and legs if there is any suspicion of it (*see Examine the Extremities and Ranges of Motion*) and record in the *Manual Muscle Testing section of the Neuromuscular Data Sheet (Part II - Appendix B)*.
8. Elicit deep tendon reflexes (see below) and record results for each reflex on each side:
 - » Brachioradialis
 - » Biceps
 - » Triceps
 - » Knee
 - » Ankle
 - *Elicit superficial and pathologic reflexes.*
9. Test each of the following sensory modalities:
 - » Light touch
 - » Pain sensation (pin prick)
 - » Proprioception (great toe positioning)
 - » Vibratory sensation
10. Test cerebellar function by:
 - » Assessing gait for ataxia or unsteadiness (see above)
 - » Finger-to-nose test
 - » Heel-to-shin test
 - » Rapid alternating movements
 - » Romberg Test with eyes open and Romberg Test with eyes closed.
11. Describe any involuntary movements or movement disorders.
12. Perform a mini-mental status examination with more in-depth testing when mental capacity is in question.
13. Assess mood and behavior during the examination and report any significant abnormalities.

Examine the Skin

Describe in detail any of the following findings, if present:

- Café au lait spots or any cutaneous lesions characteristic of neurological conditions or syndromes
- Healed surgical scars especially of the spine and cranium
- Neuropathic foot ulcers
- Other lesions or complications associated with neurological conditions or syndromes.

Review Medical Records from DDD

- If DDD has medical records on the claimant, the agency will send you some of the most pertinent records.
- Document key findings such as abnormal MRI findings in your report and incorporate these results in your clinical assessment, diagnostic impressions (*see List All of Your Diagnostic Impressions*) and functional statement (*see Provide Functional Statement ("Medical Source Statement")*).

Review Results of X-Rays or Other Tests Performed in Your Office

- If you have preformed X-rays, document the main results briefly in your narrative report.
- Incorporate these results in your clinical assessment, diagnostic impressions (*see List All of Your Diagnostic Impressions*), and functional statement (*see Provide Functional Statement ("Medical Source Statement")*).

List All of Your Diagnostic Impressions

- This is a key element of the consultative examination and report.
- Include both confirmed diagnoses plus "probable" diagnoses.
 - » Example, in a claimant with a history of a sudden right hemiparesis and aphasia a few months prior with the presence of significant residual deficits and a history of vascular disease elsewhere, it is recommended that you list "probable left brain stroke" in your list of diagnoses even though you do not have a CT or MRI report.

Provide a Functional Statement ("Medical Source Statement")

- This is an "educated estimate" of ability to physically function in the workplace for eight hours per day, five days per week.
- DDD realizes that you do not have the availability of every useful test to help you; that is why it is described as an "educated estimate."

- Use all of the data you do have, including the history, examination results, any X-rays or other tests done in your office (if applicable), and any medical records sent to you by us.
- What is most important is that you do a reasonable and realistic assessment of function based on everything you know or have discovered about the claimant's medical illnesses and functional status.
- Include the effects of symptoms if there are plausible underlying medical conditions that could cause them.
- Some important functional capacities include educated estimates of how many hours during an eight-hour workday a claimant can be on his or her feet (that is, stand and/or walk). Another important functional assessment is how much weight a claimant can lift and carry for more than two hours per day ("occasionally," which indicates up to a third of an eight hour day. Note that "frequently" indicates from a third to two-thirds of an eight-hour day).

Enter Manual Muscle Testing Results in Neuromuscular Data Sheet

- Do not delegate this to anyone else other than a licensed physical or occupational therapist, physician assistant, or nurse-practitioner.
- This form must be completed in its entirety, signed, and returned to DDD for every claimant. Testing details are given within the *Manual Muscle Testing Form (Part II - Appendix D)*.

Enter Range of Motion Testing Results in Neuromuscular Data Sheet

- Do not delegate this to anyone else other than a licensed physical or occupational therapist, physician assistant, or nurse-practitioner.
- This form must be completed in its entirety, signed, and returned to DDD for every claimant. Testing details are given within the *Manual Muscle Testing Form (see Appendix B)*.

1151 Form

- For some appeals, an administrative law judge will request an *1151 Form (Part II - Appendix D)*, which should be included in your packet. If it is requested on the voucher but not in the packet, *contact DDD*.
- An extra fee is paid for completion of a requested *1151 Form (Part II - Appendix D)* and the form is self-explanatory.
- The same principles stated in *Provide a Functional Statement ("Medical Source Statement")* should be used in completing the 1151. A copy of an *1151 Form* can be found in Part II - Appendix D.

Proofread

Signature

Sign the report personally. Stamps, electronic signatures or signatures by persons other than the consultative physician are not permitted.

Part V - Appendices

- A. Examples of Key Questions for Three Common Chief Complaints
- B. Range of Motion and Manual Muscle Testing Form (see Part II - Appendix B)
- C. Common Gait Abnormalities (see Part II - Appendix C)
- D. 1151 Form (see Part II - Appendix D)

Part V - Appendix A: Examples of Key Questions for Three Common Chief Complaints

Seizures

- A. When was your first seizure?
- B. Do you know what kind of seizures you have or been diagnosed with?
- C. Has a family member or other observer ever told you what happens when you have a seizure?
- D. Do you lose consciousness or "pass out"? Do you fall down? Do you lose control of your bowels or bladder? Have you ever realized you have bitten your tongue afterwards? How long do your seizures last? Are you unconscious or sleepy after the end of a seizure? If so, for how long?
- E. Do you know when a seizure is coming on? Do you feel strange before a seizure occurs?
- F. What tests have been done with respect to your seizures? Brain "cat" scans or CTs or MRIs? EEGs or "brainwave tests"? Do you know the results of any of these tests?
- G. What medications have you been placed on for your seizures? Can you afford the medications? Do you take the seizure medications regularly? Has anyone checked blood levels of your seizure medications? When? Were you told the blood levels were normal or high or too low?
- H. Have you ever been taken to the emergency department for a seizure? Been hospitalized?
- I. Have the medications helped prevent your seizures? Are there side effects?
- J. How often do you have a seizure? Per day? Per week? Per month? On your current medications, how often do you have seizures? What is the most frequent you had seizures? When?
- K. Do you know why you have seizures? Did you have a brain injury? Do seizures run in your family?
- L. Do you have different kinds of seizures, that is, one type of seizure sometimes an another type other times? If so, describe what you know about each type(s) of seizure.
- M. Has surgery ever been recommended for your seizures?

Note: if, in your opinion, a definite or probable seizure disorder (or pseudoseizures) are present, list this in your impressions or diagnoses near the end of your report.

Multiple Sclerosis

- A. When were you diagnosed with multiple sclerosis?
- B. What symptoms or problems were you having when you were diagnosed?
- C. Do you know what tests you have had done to make your diagnosis of multiple sclerosis? Brain "cat" or CT scans or MRIs? "Spinal taps" or lumbar punctures? Blood tests? "Electrophysiologic" studies of your vision, hearing, or other brain functions?
- D. When did you first receive treatment for multiple sclerosis? What was it?
- E. How did the treatment seem to work? Did you recover fully from your first "attack" or flare-up of multiple sclerosis or did you have continuing ("residual") problems that have never gone away? If so, what has not gone away?
- F. Tell how the course of your multiple sclerosis has gone since you were first diagnosed up to the present time? Have you had many flare-ups or has your condition gotten progressively or gradually worse? What treatments have you had over the years?
- G. Does heat bother you more now than before you were diagnosed?
- H. Do you have problems with fatigue or muscle tiredness? If so, explain in detail.
- I. Explain any difficulties you may have with your vision.
- J. Explain any difficulties you may have with using your hands.
- K. Explain any difficulties you may have with walking.
- L. Explain any difficulties you may have with fatigue or sustaining physical activities.
- M. Explain any difficulties you may have with controlling your bowels or bladder.
- N. Explain any difficulties you may have with pain.
- O. Explain any difficulties you may have with your memory or thinking or speaking?

Note: if, in your opinion, the claimant has definite or probable multiple sclerosis or a related condition, list this in your impressions or diagnoses near the end of your report.

Back pain

- A. Where is the pain?
- B. Does it stay in the back or extend to the legs? If so how far down the leg or legs?
- C. When did you first start having back pain?
- D. Does anything make the pain better?
- E. Does anything make the pain worse?
- F. Has anyone ever evaluated your back pain? If so, what was found? What were the results of any back X-rays or MRIs?
- G. Has back surgery ever been recommended?
- H. Have you ever had back surgery? Do you know specifically what was done? When did you have surgery?
- I. Do you ever lose control of your bowels or bladder?
- J. If back pain occurs with walking, how far can you walk without having to stop due to back pain?

Note: if, in your opinion, a definite or probable spine disease is present, list this in your impressions or diagnoses near the end of your report.