THE LAW OFFICES OF
Gregory K. Kornegay
ATTORNEY AT LAW

Telephone: (910) 763-5757 **Toll Free: 1-866-579-5757** **Fax: (910) 763-5677**

Attached to this letter you will find a Mental Medical Questionnaire (*Mental Impairment Questionnaire*). Please have your doctor complete the form. You should return the form to us after you pick it up from your doctor. Please remember the following:

1. **The form should be *signed by a Psychiatrist, Psychologist, or other Mental Health Professional*.**
2. This form is very important to your case as it provides medical evidence in support of your disability.
3. We cannot force your doctor to complete the form for you.
4. We do not tell the doctor how to complete the form for you.
5. The questions on the form are to gather the doctor's best estimate as to your mental limitations.
6. **SEND THE COMPLETED FORM TO US AT:**

MAIL:
Gregory Kornegay
P.O. Box 900
Wilmington, N.C. 28402; or

FAX: (910) 763-5677; or

EMAIL: gkornegay@aol.com

Sincerely,

GREGORY K. KORNEGAY

MENTAL IMPAIRMENT
QUESTIONNAIRE
(LISTINGS)

PATIENT'S NAME: _____ D.O.B.: _____

Please answer the following questions concerning your patient's impairments.

1. Frequency and length of contact:_____

2. DSM-IV Multiaxial Evaluation:

   Axis I:_____

   Axis II: _____

   Axis III: _____

   Axis IV: _____

   Axis V: Current GAF:_____

   Highest GAF Past year: _____

3. Identify your patient's signs and symptoms:

	Poor memory		Oddities of thought, perception, speech or behavior
	Appetite disturbance with weight change		Perceptual disturbances
	Sleep disturbance		Time or place disorientation
	Personality change		Catatonia or grossly disorganized behavior
	Mood disturbance		Social withdrawal or isolation
	Emotional liability		Blunt, flat or inappropriate affect
	Loss of intellectual ability of 15 IQ points or more		Illogical thinking or loosening of associations
	Delusions or hallucinations		Decreased energy
	Substance dependence		Manic syndrome
	Recurrent panic attacks		Obsessions or compulsions
	Anhedonia or pervasive loss of interests		Intrusive recollections of a traumatic experience

	Psychomotor agitation or retardation		Persistent irrational fears
	Paranoia or inappropriate suspiciousness		Generalized persistent anxiety
	Feelings of guilt/worthlessness		Somatization unexplained by organic disturbance
	Difficulty thinking or concentrating		Hostility and irritability
	Suicidal ideation or attempts		Pathological dependence or passivity

Other symptoms and remarks:_____

4. Describe the *clinical findings* including results of mental status examination which demonstrate the severity of your patient's mental impairment and symptoms: _____

5. Is your patient a malingerer? Yes No

6. Are your patient's impairments reasonably consistent with the symptoms and functional limitations described in this evaluation? Yes No

   If no, please explain:_____

7. Treatment and response:_____

8. a. List of prescribed medications:

NAME OF MEDICATION AND DOSAGE	DAILY AMOUNT TAKEN

b. Describe any side effects of medications which may have implications for working. E.g., dizziness, drowsiness, fatigue, lethargy, stomach upset, etc.:_____
_____
_____

9. Prognosis:_____

10. Has your patient's impairment lasted or can it be expected to last at least twelve months?
Yes No

11. Does the psychiatric condition exacerbate your patient's experience of pain or any other physical symptom?

Yes No

If yes, please explain:_____

_____

12. Does your patient have a low I.Q. or reduced intellectual functioning?
Yes No

Please explain (with reference to specific test results):

_____

_____

13. On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?

Never	About twice a month
Less than once a month	About three times a month
About once a month	More than three times a month

14. Would your patient have difficulty working at a regular job on a sustained basis?
Yes No

Please explain: _____

_____

15. Identify any additional tests or evaluations you would advise to fully assess your patient's impairments and limitations: _____

_____

_____

16. Indicate to what degree the following functional limitations exist as a result of your patient's mental impairment:

**Note:* Marked means more than moderate, but less than extreme. A marked limitation may arise when several activities or functions are impaired or even when only one is impaired, so long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately and effectively.

FUNCTIONAL LIMITATION		**DEGREE OF LIMITATION**				
(1)	Restriction of activities of daily living	None	Slight	Moderate	Marked*	Extreme
(2)	Difficulties in maintaining social functioning	None	Slight	Moderate	Marked*	Extreme
(3)	Deficiencies of concentration, persistence or pace resulting in failure to complete tasks in a timely manner (in work settings or elsewhere)	Never	Seldom	Moderate	Marked*	Extreme
(4)	Episodes of deterioration or decompensation within 12 month period, in work or work-like settings which cause the individual to withdraw from that situation or to experience exacerbation of signs and symptoms (which may include deterioration of adaptive behaviors)	Never	Seldom	Once or Twice	Three	Four or More

17. Can your patient manage benefits in his or her own best interest?

Yes No

_____ _____

Date Signature

Printed/Typed Name: _____

Address: _____

_____