Disability Evaluation Form

The purpose of this form is to allow Dr. Brown to easily review your history and current functioning in order to easily and effectively complete your Disability Support Letter and Residual Functional Capacity Form.

Completion of this form is optional but helpful.

Dr. Brown will need access to all of this information in some format in order to complete your documentation. Gathering it all together in one spot ensures that nothing will be missed and Dr. Brown's time can go into documentation instead of information gathering. Feel free to attach medical records, labs, etc. and reference them in your responses. We can go through this form together if we need to. Recruiting family members or caregivers to help is encouraged.

Name: **Date of Birth:**

1. **What medical diagnoses were you given prior to becoming ill?**

2. **When did you begin to experience ME/CFS symptoms? Describe the onset of your symptoms.**

3. **When were you diagnosed (if ever) with ME/CFS?**

4. **What additional diagnoses have you been given? Please comment if you believe any of these diagnoses to be inaccurate.**

5. **If any of your additional diagnoses contribute to your disability, please explain.**

6. **What diagnoses have been ruled out? Please include the diagnosis and the test or evaluation that ruled it out.**

7. **Place a check next to any of the following symptoms that you experience and describe in detail below. Please select any that you experience, even if only occasionally. Please take your time and make sure you answer all the questions. You do not have to complete the questionnaire all at once, as long as all questions are answered (patients assigned male at birth do not answer questions 49 and 50):**

1. I suffer from physical fatigue	☐
2. My concentration is reduced	☐
3. I have difficulty getting to sleep	☐
4. I often have vivid/weird dreams	☐
5. My sleep is usually disturbed or I wake up feeling unrefreshed	☐
6. I have problems with short term memory	☐
7. I find it difficult to read	☐
8. I get ‘fuzziness’ in the head / brain fog	☐
9. I suffer from sinusitis	☐
10. I suffer from head pain / discomfort	☐
11. I suffer from neck pain / discomfort	☐
12. I suffer from shoulder pain / discomfort	☐
13. I suffer from upper back pain / discomfort	☐
14. I suffer from lower back pain / discomfort.	☐
15. I suffer from other joint pain/discomfort.	☐
16. I suffer from joint swelling.	☐
17. I suffer from general muscle pain / discomfort.	☐
18. I often suffer from numbness.	☐
19. I often suffer from pins and needles.	☐
20. I suffer from redness in the face.	☐
21. I suffer from frequent rashes.	☐

22. I suffer from dry skin.	☐
23. I suffer from frequent acne on my forehead.	☐
24. I suffer from frequent acne on my back.	☐
25. I suffer from frequent acne on my chest.	☐
26. I feel depressed.	☐
27. I feel anxious.	☐
28. I suffer from panic attacks.	☐
29. I am sensitive to bright light.	☐
30. I am sensitive to loud noise.	☐
31. My temperature fluctuates.	☐
32. I suffer from bad breath.	☐
33. I suffer from thrush.	☐
34. I have problems with my bowels or digestion.	☐
35. I have problems with my bladder.	☐
36. I am sensitive to smells.	☐
37. I have food intolerances/allergies.	☐
38. I have lumpy breasts.	☐
39. I have tenderness/pain in the chest.	☐
40. I am frequently breathless.	☐
41. I suffer from palpitations.	☐
42. I suffer from sore throats.	☐
43. I suffer from nausea.	☐
44. I suffer from dry eyes.	☐
45. I suffer from dry mouth.	☐
46. I sweat a lot.	☐

47. I suffer from cold hands/feet.	☐
48. I suffer from mood swings.	☐
(The final two questions are for assigned female at birth patients only.)	
49. I suffer from PMS.	☐
50. My symptoms are worse during my periods.	☐
51. I suffer from a worsening of my symptoms after exertion that lasts at least 24 hours and is out of proportion to the exertion.	☐
52. I suffer from tender or swollen lymph nodes in my neck, groin or armpits.	☐
53. I suffer from muscle weakness.	☐
54. I suffer from pain in multiple joints.	☐
55. My brain fog is severe enough to cause a substantial reduction in previous levels of occupational, educational, social, or personal activities.	☐

Please take the box that you feel best describes your symptom picture.
Following mental or physical exertion, do your symptoms

a. ❒ Always improve.
b. ❒ Sometimes improve.
c. ❒ Always worsen.
d. ❒ Sometimes worsen.
e. ❒ May sometimes initially improve but worsen within three days.

8. **Which of the following medical signs have your physicians previously documented? Check the box and reference the note if possible.**
    - ☐ Swollen lymph nodes (lymphadenopathy)
    - ☐ Crimson crescents (non-edudative pharyngitis)
    - ☐ Tender sinuses (sinusitis)
    - ☐ Pale complexion (pallor)
    - ☐ Muscle tenderness (positive tender points on exam)
    - ☐ Frequent viral infections with prolonged recovery
    - ☐ Poor coordination (ataxia)
    - ☐ Pronounced weight change

9. **Which of the following laboratory evaluations have you had? What were the results?**
    - ☐ Epstein-Barr virus early antigen IgG antibodies
    - ☐ MRI of the brain
    - ☐ Tilt table testing
    - ☐ NASA Lean or Standing Test

10. Which of the following treatments have you tried? What were the results?

- ☐ Pacing education
- ☐ Energy-conserving occupational therapy
- ☐ Self-led pacing therapies such as using a wearable to keep heart rate below a certain level
- ☐ Mobility aids
- ☐ Sensory aids
- ☐ Low dose naltrexone
- ☐ Low dose Abilify
- ☐ Stimulants
- ☐ Graded exercise therapy
- ☐ Exercise-based physical therapy
- ☐ Psychotherapy (such as cognitive behavioral therapy or talk therapy)
- ☐ SSRIs or antidepressants
- ☐ Over the counter sleep aids
- ☐ Prescription sleep aids
- ☐ B12 injections
- ☐ Vitamin D
- ☐ Fluids, electrolytes
- ☐ Compression garments
- ☐ Beta blockers
- ☐ Mestinon (pyridostigmine), Midodrine or Fludrocortisone
- ☐ Antihistamines
- ☐ Prescription mast cell stabilizers
- ☐ Other MCAS treatments
- ☐ Nutritional supplements
- ☐ Mitochondrial support supplements
- ☐ Antioxidant supplements
- ☐ Methylation supplements
- ☐ Other:

11. What did you previously do for work?

12. When did you stop working and why? If you stopped due to symptoms, describe in detail how your symptoms affected your ability to work day to day and week to week.

13. Check all of the following that apply to you and describe below:

- ☐ Trouble focusing the eyes
- ☐ Sensitivity to screens
- ☐ Sensitivity to fluorescent lights
- ☐ Sensitivity to noise
- ☐ Sensitivity to heat
- ☐ Sensitivity to cold
- ☐ Sensitivity to detergents or fragrances
- ☐ Sensitivity to vibrations
- ☐ Sensitivity to mold
- ☐ Other sensitivities

Good Days

While there may never be a true “good” day with chronic illness, there are often “better” or more functional days. Indicate your hours of upright activity and the level of function you experience on good or better illness days.

How many good days do you average in a month:

In a 24-hour period, how many hours of upright activity do you engage in on a good day?
(Upright activity is defined as time spent with feet on the floor including sitting, standing and walking).

How many hours of non-upright activity (feet elevated, lying flat) do you engage in?

For the following, consider:

- **Personal hygiene and basic functions** (using the bathroom, bathing, getting dressed, getting out of bed)
- **Walking and moving around** (around the house and outside, physical activities that increase heart rate)
- **Being upright** (sitting in bed, sitting in a chair, standing in a line or while cooking)
- **Activities in the home** (dusting and other light housework, vacuuming and other moderate intensity housework, laundry, making a simple cold meal, making a hot meal)
- **Communication** (speaking, writing, socializing with a friend, socializing at a party or event)
- **Activities outside the home** (errands, shopping, riding in the car, driving, using public transportation, working, going to class)
- **Reacting to light or sound** (staying in a dimly or brightly lit room, staying outdoors on a sunny day, staying in a noisy environment such as a restaurant, going to a cinema or concert with high noise levels)
- **Cognitive processing** (reading, answering text messages/emails, watching TV, filling out disability paperwork, etc.)

Give examples of activities/tasks you CAN do on a GOOD day:

Give examples of activities/tasks you CANNOT do on a GOOD day:

Bad Days

Indicate your hours of upright activity and the level of function you experience on bad or worsened illness days.

How many bad days do you average in a month:

In a 24-hour period, how many hours of upright activity do you engage in on a bad day?
(Upright activity is defined as time spent with feet on the floor including sitting, standing and walking).

How many hours of non-upright activity (feet elevated, lying flat) do you engage in?

For the following, consider:

- **Personal hygiene and basic functions** (using the bathroom, bathing, getting dressed, getting out of bed)
- **Walking and moving around** (around the house and outside, physical activities that increase heart rate)
- **Being upright** (sitting in bed, sitting in a chair, standing in a line or while cooking)
- **Activities in the home** (dusting and other light housework, vacuuming and other moderate intensity housework, laundry, making a simple cold meal, making a hot meal)
- **Communication** (speaking, writing, socializing with a friend, socializing at a party or event)
- **Activities outside the home** (errands, shopping, riding in the car, driving, using public transportation, working, going to class)
- **Reacting to light or sound** (staying in a dimly or brightly lit room, staying outdoors on a sunny day, staying in a noisy environment such as a restaurant, going to a cinema or concert with high noise levels)
- **Cognitive processing** (reading, answering text messages/emails, watching TV, filling out disability paperwork, etc.)

Give examples of activities/tasks you CAN do on a BAD day:

Give examples of activities/tasks you CANNOT do on a BAD day: