[redacted]

Counseling and Evaluations, PLLC

[redacted]

Psychological Evaluation

Name: [redacted]
Date of Birth: 8/26/1988
Setting: [redacted] Counseling and Evaluations, PLLC
Evaluator: [redacted], Psy.D.
Date of Evaluation: 11/15/201[redacted]

Identifying Information

[redacted] is a [redacted]-year-old mixed race (African American/Caucasian) man who was referred for psychological evaluation by his attorney, Travis Hansen, secondary to his application for Social Security Disability benefits. Mr. [redacted] is currently unemployed and lives with his mother, [redacted], in [redacted] Ms. [redacted] paid for the evaluation. He was prompt for his 10:00 AM appointment and was driven by his mother. He walked normally and did not require assistance. He signed a consent to undergo psychological inquiry, an apprisal of his rights and a release of information for the report to be given to Mr. Hansen.

Sources of information

Clinical Interview with [redacted] on 11/15/16 & 11/22/16
Interview with Andrea [redacted] on 11/22/16
Discharge Summary by [redacted], MD, dated 5/13/14
Psychiatric Evaluation by [redacted] ARNP, dated 5/2/14
Psychiatric Evaluation by [redacted], DO, dated 9/18/12
Medication Review by [redacted], DO, dated 8/30/13
Psychiatric/Psychological Medical Report, by [redacted], MS, dated 1/24/13
Progress Note by [redacted], MN, PMHNP-BC, dated 11/18/14
Clinical Message by [redacted], ARNP, dated 4/2/14
Complete Evaluation/Intake by [redacted], Dated 4/2/14
Psychological testing

Psychosocial History

[redacted] was born on August [redacted] in [redacted] to his parents [redacted], who was in the military, and [redacted] who was [redacted]. The small family moved back to the United States before [redacted] first birthday and first settled in [redacted], followed by [redacted] and finally [redacted]. To the best of his knowledge Mr. [redacted] denied any knowledge of his mother drinking

to excess or using drugs while she was pregnant with him; a belief corroborated by Ms. [redacted]. He grew up with one older sister, [redacted] who is three years his senior.

Mr. [redacted] believes he met developmental milestones within expected parameters, for example walking by age 1 and speaking by age 2. He believed he was a "good boy" and related to his peers well. Mr. [redacted] stated he was disciplined primarily through rare corrective spanks and timeouts. At no time did he ever feel that his punishments were abusive. Ms. [redacted] described her son as being a shy boy who would speak at home more than he would in public in his early years. Even though English was his first language, Ms. [redacted] would sometimes use [redacted] phrases. His led to Mr. [redacted] being placed in "English as a second language" classes.

Educationally, Mr. [redacted] attended Pre-Kindergarten in [redacted] and elementary school, middle school, and high school in [redacted] He stated he was not a good student and from a very young age needed assistance with reading. He repeated the 1st grade. When asked if he had ever been placed on an individualized education program (IEP) he stated, "I think so. I remember sitting with the teachers and them talking to me about goals that I was to achieve for the next semester or so." This was confirmed by his mother who stated, "He was on an IEP throughout his school years." Mr. [redacted] stated that by the time he was into his third year of high school he required less assistance and successfully graduated in 20[redacted].

Regarding his vocational history, Mr. [redacted] stated that his first job was making [redacted] at a [redacted]; a job that lasted just over two years. It was during this time that he first began hearing voices. He later worked at an [redacted] where he first broke down emotionally and was asked to resign. He stated, "I told the manager about what I was experiencing and she thought it was best that we part ways." It was during this job that his voices became louder and functionally impairing. He stated he began arguing with the voices while he was on the job and would feel quite angry and irritable due to his inability to control them. He worked at several other restaurants during this time with similar results. His last termination of employment occurred while he was working at an [redacted] restaurant when he, again, could not control the voices and was observed responding to internal stimuli. He had not yet been diagnosed with a mental illness at this time and was frightened over his seeming deterioration. He stated that the longest period of time he held the same job was his two years at Subway.

Mr. [redacted] stated he has a legal history that includes such charges as possession of a controlled substance and possession of paraphernalia. He stated, "I know I have other charges but I don't remember what they are. But I've been to jail, like, 12 times or something." As a teenager he reported becoming increasingly paranoid while he drove, being an African-American man in a predominantly white culture. He stated, "I was pulled over like 50 times. That made my paranoia a lot worse because I thought the police and the FBI were out to get me." Mr. [redacted] stated that the jail staff began to get to know him and eventually began giving him his own cell due to the obvious nature of his mental illness. Mr. [redacted] has had no legal difficulties since arriving in [redacted]

Regarding his alcohol and drug use, Mr. [redacted] stated he began smoking tobacco and sipping alcohol when he was 12. The record indicates he experimented with various illegal drugs, such as cocaine, cannabis, LSD, etc., when he was in high school. "Marijuana is really the only thing I

use now." He said he uses cannabis several times a week and that it helps him relax and "sleep, sometimes." He was previously diagnosed with cannabis dependence, but could not cite the functional impairment necessary for the diagnosis, nor was he ever treated with counseling or take part in a formal treatment program. This was corroborated by his mother. His most recent case note [redacted], 11/2014) does not list a cannabis use disorder as a relevant diagnosis.

Regarding his psychiatric history, Mr. [redacted] began experiencing perceptual disturbances when he was 16 years old, in the form of auditory hallucinations. He admitted that these and other symptoms of psychosis, such as delusional beliefs and paranoia, increased in both frequency and severity during his 20's. When the voices became functional impairing, Mr. [redacted] said his reaction was to become angry. "I'd get mad and lash out at others." His anger included agitation, profanity, yelling, "and sometimes throwing or breaking things." These were first diagnosed in 2012 as bipolar I disorder with psychotic features ([redacted], DO, 10/10/12) with a rule-out of schizoaffective disorder. A Psychiatric/Psychological evaluation by [redacted], MS ([redacted], Ph. D, supervisor) in January of 2013 confirmed schizoaffective disorder, bipolar type. This became Mr. [redacted] primary diagnosis until 2014 when [redacted] (ARNP, 6/13/14) diagnosed Mr. [redacted] with Schizophrenia, paranoid type, opining that the manic-like episodes were a reaction to the increased voices, "Therefore I do not think there is a true manic episode." Despite this rationale, [redacted] (MN, PMHNP-BC, 11/18/14) continued the schizoaffective disorder, bipolar type, as his current diagnosis. This issue will be discussed later in the Summary section of this report.

Depression and anxiety were found in his psychiatric history as well and seem to be frequently comorbid with his thought disorder. Early in life, Mr. [redacted] was diagnosed and treated for ADHD and prescribe psychostimulants at first, followed by atomoxetine later in life. The record cites the use of many antipsychotic medications with limited success, including Haldol, Geodon, Abilify, Seroquel and Risperdal. He stated Risperdal works the best at muffling the voices, "though not entirely." His current (11/15/16) medication regimen is as follows:

Medication	Dose	Indication	Last taken
Klonopin	.5mg BID	Anxiety	11/15/16
BusPar	20 mg TID	Anxiety	11/15/16
Risperdal	2 mg QAM 3mg QHS	Psychosis	11/15/16
Seroquel	200 mg QHS	Psychosis	11/14/16
Flexoril	10 mg TID	Back pain	11/15/16
Lansoprazole	30 mg QAM	Acid Reflux	11/15/16

Mr. [redacted] medical history was notable for being treated for [redacted] in the 7th and 8th grades and is otherwise unremarkable. He did comment, however, "After the bacterial meningitis, I never felt the same."

For relaxation, Mr. [redacted] stated he enjoys few things, though video games are among his interests. He stated his constant fatigue, likely due to his medication regimen, prevents him from having the energy to be more active and pursue formerly enjoyed activities, such as sports and skateboarding.

Regarding his activities of daily living, Mr. [redacted] stated that his days consist of getting up and making a cup of coffee. He called this "processing time" as he would consider what he wanted to do with his day. He would then let his dog out, watch some television and take a nap. This routine of watching television followed by a short nap would be repeated throughout the day. He stated he does not really do chores around the house due to his inability to follow through. He stated he has notable difficulties in completing what he starts, even such mundane tasks as walking his dog. He does not cook and rarely cleans. He stated, "I spend a lot of time in my room by myself due to the voices. I'm always agitated." Socially, Mr. [redacted] stated that he has no social life to speak of, believing that the last time he did something socially on his own was, "about six months ago." He did state that he makes some effort to purchase cannabis due to the positive effects it has on his mood.

Mr. [redacted] reported several periods of decompensation to the point that he needed to be hospitalized psychiatrically. He reported three such hospitalizations, most recently in 201[redacted] at [redacted] Hospital.

Behavioral Observations

Mr. [redacted] presented as a well-nourished man who appeared his stated age [redacted] years. He wore a striped shirt under a brown camouflage jacket and blue jeans. He wore a white knit cap throughout the assessment: attire that was appropriate for the day's weather, though unusual for a 3-hour assessment. He sported a short beard and was otherwise unshaved. His overall personal hygiene was fair. He stated he had eaten in the morning and accepted this writer's offer of a cup of coffee. He asked that his mother be present during the entirety of the evaluation process. This was expected due to the level of paranoia exhibited.

Mr. [redacted] was largely cooperative, though initially wary, during the assessment. His affect was predominately flat and he displayed mild to moderate psychomotor retardation, seen primarily in the latencies between questions and answers. His ability to concentrate was notably impaired, as seen in his completion of the MCMI-IV. Mr. [redacted] had only completed 16 of the 185 True/False questions after 40 minutes. He allowed this writer to read him the questions while he recorded his answers, resulting in a completed protocol. There was no evidence of malingering in that his statements and behavior were congruent with other sources of information.

Mr. [redacted] described his mood as down and anxious. He was able to muster up a weak smile at this writer's attempt at humor to build rapport and appeared tired. He stated his medication regimen results in notable somnolence making it "hard to do anything."

Mr. [redacted] thought processes were mildly tangential with topics discussed. He said he continued to hear muffled voices despite his medication, as well as constant suspiciousness and paranoia. He stated that he felt safe from self-harm and denied suicidal or homicidal ideation.

Appropriate conversational levels of volume were maintained throughout the assessment. His eye contact was fairly direct.

Assessments Utilized (In order of administration)

Mental Status Examination
Millon Multiphasic Personality Inventory, 4th Edition (MCMI-IV)
Kaufman Brief Intelligence Test- 2nd Edition (K-BIT2)
MINI International Neuropsychiatric Interview (MINI)

Assessment Results
Mental Status Examination

Mr. [redacted] was oriented to person, time and purpose. He could not recall the name of the building we met in [redacted] Medical Tower), the floor we were on ([redacted]), or the name of the business ([redacted]).

He was unable to recall two of three words after 5 minutes.

Mr. [redacted] correctly described "people being mad because Trump won" and the "Dakota pipeline thing" as being examples of current events. He correctly named "Bush, Clinton and Bush" as the three previous presidents to president Obama and correctly identified Canada, [redacted] as bordering the state of [redacted].

Mr. [redacted] completed serial 7s with no mistakes (93, 86, 78 ,72, 65). The digit span subtest from the Wechsler Adult Intelligence Scale was completed due to its strength in identifying problems with short-term memory. Mr. [redacted] recalled six digits forward and only three backward, frequently becoming confused on the reverse sequencing of numbers.

Regarding his ability to abstract, Mr. [redacted] was asked to interpret the proverb *Rome wasn't built in a day.* He replied, "Things take time." He could not interpret the proverbs, *A rolling stone gathers no moss,* or *A stitch in time saves nine.*

Regarding his insight and judgment, when asked what he would do if he found a wallet on the floor of the department store, Mr. [redacted] said "I would give it to the manager." When asked what he would do if he found an unmailed letter with a stamp on it on the sidewalk, he stated "I would mail it." Lastly when asked what he would do if he smelled smoke in a crowded theater, Mr. [redacted] replied, "I would evacuate and shout 'Smoke!'"

Cognitive Ability Assessment

Cognitive testing was then completed to determine Mr. [redacted] level of intellectual functioning. The K-BIT2 was utilized due to its sound psychometric properties and good reputation in providing an accurate estimate, or "IQ Composite" of a person's cognitive ability. The K-BIT2 measures intelligence across two domains; the Verbal scale comprised of Verbal Knowledge and Riddles, and a Non-Verbal domain comprised of Matrices, which measure problem-solving abilities. Mr. [redacted] results are listed below:

Vocabulary

Verbal Knowledge 45
Riddles 35
Standard score = 86 (80 - 94 at 90% confidence Interval)
Percentile Rank: 18th
Descriptive Category: Average

Matrices

Matrices = 33
Standard score = 92 (84 - 101 at 90% confidence Interval)
Percentile Rank: 30th
Descriptive Category: Average

Composite IQ = 87 (89 – 99 at 90% confidence interval)
Percentile Rank = 19th
Descriptive Category= Average

Mr. [redacted] produced a Composite IQ of 87, indicating average intelligence at the 19th percentile, with no notable deficits in either domain. These results suggest that Mr. [redacted] has adequate ability to navigate through life if intelligence were the only factor.

Personality Assessment

Mr. [redacted] personality was assessed with the MCMI-IV. This test is the newest version (2016) of this respected psychological inventory that has strengths in not only identifying features of a mood disorder but also personality factors that may be impinging on an individual's life.

Beginning with the three validity scales, called *Modifying Indices*, Mr. [redacted] responses indicate a good ability to disclose and a strong tendency to be self-critical. If an individual without psychiatric problems had his profile, the results would be considered to be somewhat exaggerated. Mr. [redacted] notable history of mental illness, however, make this a valid profile that was suitable for interpretation.

Regarding his results on the Clinical Personality Patterns, Mr. [redacted] was notably elevated on the Avoidant scale. Individuals with this scale elevation experience very little positive reinforcement from themselves or others. They are isolated individuals who are typically always "on their guard" and ready to distance themselves from emotionally painful experiences. These individuals fear and mistrust others. Despite their desires to relate to others, they have learned that it is best to deny these feelings and to keep a good measure of interpersonal distance. It should be noted that individuals with schizophrenia and significant paranoia score high on this personality scale.

Regarding the Severe Personality Pathology scales, Mr. [redacted] was significantly elevated on the Paranoid Scale. Individuals with scores as high as Mr. [redacted] display a vigilant mistrust of others and defensiveness against anticipated criticism and deception. They typically possess an abrasive irritability and a tendency to precipitate anger in others. These individuals are distinctive in the immutability of their feelings and the inflexibility of their thoughts. They often expressed fear of

losing independents leading them to vigorously resist external influences and control. Mr. [redacted] history is full of examples of these tendencies due to his symptoms or psychosis.

A further look at Mr. [redacted] paranoia resulted in extremely high subscales making up the Paranoid scale. These are titled Expressively Defensive, Cognitively Mistrustful and Projection Dynamics. Those who are Expressively Defensive are seen as vigilant individuals who maintain a hypersensitive wariness in order to ward off anticipated deception and malice from others. Those that are Cognitively Mistrustful are suspicious regarding the motives of others and tend to misconstrue even innocuous events, seeing these as "proof" of duplicity or conspiratorial intent. Preoccupied with mistrustful thoughts, individuals like Mr. [redacted] are notoriously hypersensitive and disposed to detect signs of trickery and deception at every turn. This scale was Mr. [redacted] *highest elevation* on the entire test. Finally, individuals with high Projection Dynamics disown undesirable personality traits and motives and attribute them to others. They are often blind to their own maladaptive behavior and characteristics, yet are accomplished at spotting other's more inconsequential deficiencies. These people are often touchy and irritable; a trait clearly seen in the record.

Regarding the scales measuring Clinical Syndromes, Mr. [redacted] was prominently elevated on the scales measuring Generalized Anxiety. Individuals with an Anxiety scale elevation are seen as being in a state of tension and have difficulty relaxing. They are potentiated to react and are easily startled. They often complain of various types of physical discomforts such as ill-defined muscle aches, excessive perspiration and nausea. Mr. [redacted] is currently being treated with two medications to control the persistent anxiety and worry.

Finally, on the scales measuring Severe Clinical Syndromes, Mr. [redacted] was notably elevated on the scales measuring Major Depression and Delusions. Individuals with depression scales as elevated as Mr. [redacted] are usually incapable of functioning in a normal environment and often present with a pessimistic outlook of the future. They tend to have a pervasive sense of hopelessness and are frequently fearful and brooding. Physically, some of these individuals may exhibit marked psychomotor retardation, as seen in today's assessment, while others display agitation. Individuals with a high Delusional scale are frequently considered acutely paranoid and may become periodically belligerent, voice irrational but interconnected delusions of a jealous, persecutory, or grandiose nature. They may exhibit signs of disturbed thinking and ideas of reference and may possess an overarching suspiciousness and vigilance to possible betrayal. They often feel picked on and mistreated by others. Again, these traits have been clearly observed by his mental health providers

The scales measuring drug and alcohol use were within normal limits.

Other Testing Results

The diagnostic criteria for the major mood disorders as listed in the DSM-V were reviewed via the MINI. This is a structured Yes/No interview that can be susceptible to manipulation if the interviewee is intent on doing so. When, honest it provides a helpful snapshot of their own self-perceived distress as their endorsed symptoms align with DSM-5 criteria.

Mr. [redacted] responses met the diagnostic criteria for major depressive disorder. He endorsed a current depressed or down mood, most of the day nearly every day for the past several months. He endorsed significant anhedonia, decreased appetite, trouble sleeping, and psychomotor retardation- again a trait seen throughout the day. He reported feeling tired or without energy on a daily basis as well as difficulty concentrating or making decisions nearly every day. He reported that the symptoms cause significant problems at home and socially. These were corroborated on the MCMI-IV.

Mr. [redacted] denied any suicidality, though did report one previous suicide attempt in 20[redacted]. He stated he currently feels safe and is not a threat to himself.

Mr. [redacted] reported periods of time when his mood was unusually elevated and irritable for several weeks though did not endorse the full symptoms of a manic episode. He denied panic, social anxiety, obsessive-compulsive symptoms, or symptoms of posttraumatic stress. The diagnostic criteria were not met for an alcohol or substance use disorder, including cannabis, again corroborating his MCMI-IV findings.

The diagnostic criteria for schizophrenia were met. He endorsed symptoms of paranoia, believing that individuals were plotting against him. He currently believes that people can read his mind or hear his thoughts and endorsed believing that he is sometime sent special messages through the TV. He stated with a laugh that these things happen, "all the time!" He endorsed auditory hallucinations that continue, though muffled, despite his current medication. During the clinical interview and telephone interview his speech was occasionally tangential and there was affective flattening typical of this disorder.

Lastly, Mr. [redacted] endorsed the diagnostic criteria for generalized anxiety disorder. He reported that in the last six months, more often than not, he worried excessively about minor or routine things. He stated that these anxieties and worries are present most days and that they are difficult to control. Physically, he reported feeling, keyed-up or edgy on a regular basis. He stated he becomes weak or exhausted easily has difficulty concentrating, finds his mind going blank, and has persistent feelings of irritability. His current treatment regimen addresses these symptoms specifically.

Summary

[redacted] [redacted] is a [redacted]-year-old man who underwent 3 hours of psychological inquiry secondary to his application for Social Security Disability benefits. He was referred by his attorney, Travis Hansen and was accompanied by his mother, who Mr. [redacted] asked to attend the entirety of the evaluation.

His background is notable for frequently family relocations during his first five years of life due to his father's military reassignments. He was a shy child, though met developmental milestones within expected parameters. Schooling was difficult due to reading problems that resulted in his repeating the 1st grade and placement on an IEP throughout his educational years. He graduated from high school in 20[redacted] and briefly attended [redacted] school before dropping out due to his psychotic symptoms.

Auditory hallucinations, paranoia and delusional beliefs began at the age of 16 and worsened in his 20's. The auditory hallucinations became functionally impairing and were the basis of his losing several jobs and committing several crimes. He would become angry and act out in attempts to distract himself from the voices, leading to an initial diagnosis of bipolar I disorder with psychotic features. This was amended to schizoaffective disorder and finally schizophrenia. Decompensation resulted in three psychiatric hospitalizations. He is currently on a steady medication regimen that includes antipsychotic and anxiolytic medication.

Mr. [redacted] testing revealed a man of average intelligence with a notable thought disorder that includes suspiciousness, paranoia, delusional beliefs, anxiety and a low mood. His short-term memory is compromised and his concentration is quite poor. Judgment and the ability to abstract are below average. Mr. [redacted] is wary, hypervigilant, distrustful and expects others to do him harm. He reports that the medication muffles the voices to a degree, but not entirely. The paranoia and delusional beliefs remain a constant regardless of medication.

Diagnostic Impressions

On the basis of the test findings, recorded sources of information and Mr. [redacted] self-report, the following DSM-5 diagnosis is offered.

F20.9 Schizophrenia, Continuous, Without Good Prognostic Features

There has been diagnostic disagreement among Mr. [redacted] care providers between schizoaffective disorder, bipolar type, or schizophrenia. I believe the latter to be most accurate due to the voices and paranoia being present whether or not Mr. [redacted] is experiencing a mood event. I concur with [redacted] (ARNP, 2014) who opined that the anger and agitation he experiences when the voices are loud fall short of mania. Additionally, even if a mood event was present during some of his acute phases, the majority of the time he experiences the hallucinations and delusions a mood disorder is not present. The prognosis for Mr. [redacted] is less than optimal due to his significant use of various neuroleptic medications without full remission, and intense somnolence when there is success in muffling the voices. The paranoia and delusions continue to be experienced on a regular basis.

F33.1 Major Depressive Disorder, Recurrent, with Moderate Anxious Distress

Mr. [redacted] experiences symptoms of depression and anxiety on a daily basis. It is uncertain if the low energy, anhedonia and poor concentration are merely side effects of the medication, or are exacerbated by the medication. I suspect it is the latter. I believe the anxiety he experiences is contained with the chronic depressive episode, and is not a separate diagnosis. The three anxious features endorsed by Mr. [redacted] and evidenced in the record and the testing results are as follows:

*Feeling mentally tense and keyed up
*feeling restless
*difficulty concentrating.

Capacity to manage funds

Mr. [redacted] short-term memory and concentration are impaired, the latter quite noticeably. While he had no difficulty with calculation numbers, naming is mother as payee is recommended nonetheless.

Functional assessment

Mr. [redacted] distractibility, auditory hallucinations and persistent paranoia would make working alongside coworkers all but impossible. His short term memory difficulties would compromise his ability to follow instructions from a supervisor and he would likely be unable to sustain concentration. His difficulty following through with tasks would compromise any employment opportunity.

His social interactions are limited in that he isolates himself. The data from the MCMI-IV suggests he would have great difficulty adapting to a changing environment due to his low frustration tolerance. His symptoms of psychosis and physical problems make working a regular 40-hour work week extremely unlikely, if not impossible.

Thank you for the referral,

[redacted]
[redacted], Psy.D.
Clinical Psychologist

MEDICAL SOURCE STATEMENT OF ABILITY TO DO WORK-RELATED ACTIVITIES (MENTAL)

NAME OF INDIVIDUAL [redacted]

SOCIAL SECURITY NUMBER [redacted]

Please assist us in determining this individual's ability to do work-related activities eight hours a day for five days a week, or an equivalent work schedule.

Assess the individual's ability to perform the activity by using the following definitions for the rating terms:

None -- No limitations.

Slight -- The individual would lack the ability to function satisfactorily in this area from 1 percent up to 14 percent of an eight-hour workday, five days per week, 50 weeks per year.

Moderate -- The individual would lack the ability to function satisfactorily in this area from 15 up to 20 percent of an eight-hour workday, five days per week, 50 weeks per year.

Marked -- The individual would lack the ability to function satisfactorily in this area from 21 up to 33 percent of an eight-hour workday, five days per week, 50 weeks per year.

Extreme -- There is extreme limitation in this area. An extreme limitation means the individual would lack the ability to function satisfactorily in this area more than 33 percent of an eight-hour workday, five days per week, 50 weeks per year.

PLEASE COMPLETE THIS FORM FOR THE PERIOD FROM July 2, 20[redacted] THROUGH THE PRESENT

	None	Slight	Moderate	Marked	Extreme
A. UNDERSTANDING AND MEMORY					
1. The ability to remember locations and work-like procedures.	☐	☒	☐	☐	☐
2. The ability to understand and remember very short and simple instructions.	☐	☐	☐	☒	☐
3. The ability to understand and remember detailed instructions.	☐	☐	☐	☐	☒
B. SUSTAINED CONCENTRATION AND PERSISTENCE					
4. The ability to carry out very short and simple instructions.	☐	☒	☐	☐	☐
5. The ability to carry out detailed instructions.	☐	☐	☐	☐	☒
6. The ability to maintain attention and concentration for extended periods.	☐	☐	☐	☐	☒
7. The ability to perform activities within a schedule, maintain regular attendance, and be punctual within customary tolerances.	☐	☐	☐	☒	☐
8. The ability to sustain an ordinary routine without special supervision.	☐	☐	☐	☐	☒

9. The ability to work in coordination with or proximity to others without being distracted by them.	☐	☐	☐	☒	☐
10. The ability to make simple work-related decisions.	☐	☒	☐	☐	☐
11. The ability to complete a normal workday and workweek without interruptions from psychologically-based symptoms and to perform at a consistent pace without an unreasonable number and length of rest periods.	☐	☐	☐	☐	☒
C. SOCIAL INTERACTION					
12. The ability to interact appropriately with the general public.	☐	☐	☐	☒	☐
13. The ability to ask simple questions or request assistance.	☐	☒	☐	☐	☐
14. The ability to accept instructions and respond appropriately to criticism from supervisors.	☐	☐	☒	☐	☐
15. The ability to get along with co-workers or peers without distracting them or exhibiting behavioral extremes.	☐	☐	☐	☐	☒
16. The ability to maintain socially appropriate behavior and to adhere to basic standards of neatness and cleanliness.	☐	☐	☐	☐	☒
D. ADAPTATION					
17. The ability to respond appropriately to changes in the work setting.	☐	☐	☐	☐	☒
18. The ability to be aware of normal hazards and take appropriate precautions.	☒	☐	☐	☐	☐
19. The ability to travel in unfamiliar places or use public transportation.	☐	☒	☐	☐	☐
20. The ability to set realistic goals or make plans independently of others.	☐	☒	☐	☐	☐

Please identify the factors (e.g., medical signs, treatment, observations, evaluations) that support your assessment.

Clinical Interview of Mr [redacted], his mother, & review of the record & psychological testing.

[redacted]
Signature

11/24/16
Date