IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF TENNESSEE
WESTERN DIVISION

PATRICIA PATTERSON,	)	
	)	
Plaintiff,	)	
	)	
v.	)	**NO. 05-1023 B/An**
	)	
JO ANNE BARNHART	)	
Commissioner of the Social	)	
Security Administration,	)	
	)	
Defendant.	)	

REPORT AND RECOMMENDATION

Before the Court is Plaintiff Patricia Patterson's appeal of the denial of a period of disability and disability insurance benefits under Title II of the Social Security Act by Defendant Jo Anne Barnhart, Commissioner of Social Security ("Commissioner"). The appeal was referred to the United States Magistrate Judge for a report and recommendation pursuant to 28 U.S.C. § 636(b)(1). For the reasons set forth below, it is recommended that the decision of the Commissioner be **AFFIRMED**.

PROCEDURAL HISTORY

Patricia Patterson first applied for Social Security Disability benefits pursuant to Title II of the Social Security Act on March 12, 2002 alleging that she had been unable to work since January 28, 2002 due to osteopenia of the hips, fibromyalgia, stress urinary incontinence, heart disease, carpal tunnel syndrome, a nervous condition, anxiety attacks, and depression. Her application was denied both initially and upon reconsideration, whereupon Plaintiff timely filed

a request for a hearing. An administrative hearing was held on August 7, 2003 before an Administrative Law Judge ("ALJ") who denied Plaintiff's claim on November 25, 2003. Plaintiff appealed the decision of the ALJ to the Appeals Council which declined to consider Plaintiff's appeal on January 5, 2005, leaving the ALJ's decision as the final decision of the Commissioner of Social Security. Plaintiff now appeals to this Court, pursuant to 42 U.S.C. § 405(g). She argues that the ALJ's decision was not supported by substantial evidence and that the ALJ applied incorrect legal standards.

FACTUAL BACKGROUND

Plaintiff was born on November 18, 1941 and was sixty-one (61) years old at the time of the hearing before the ALJ. She has a high school diploma and more than twenty-two (22) years of work experience. Plaintiff's initial job was in the Warrants Division of the Madison County, Tennessee Sheriff's Department, where she worked from 1979 to 2000. While employed at the Sheriff's Department, Plaintiff would sit for six and one half (6 ½) hours, write for almost the entire day, and walk or stand for about one and a half (1 ½) hours each day. She would also frequently lift ten (10) pounds. TR 57. Plaintiff left the Sheriff's Department because her workload increased to "triple of what it was" originally. TR 381. Her most recent employment was as an office manager at Heritage Inn in Humboldt, Tennessee from 2000 until 2002. Plaintiff's position at Heritage Inn made her responsible for the overall management of the twenty-seven (27) room motel. She was required to walk or stand seven (7) to eight (8) hours, sit for a couple of hours, and climb, kneel, stoop or crouch for about one hour each per day. Plaintiff was also required to check each room after the housekeepers had completed their assigned tasks. Plaintiff ceased to be employed by Heritage Inn on January 28, 2002 when the

motel was sold.

Plaintiff suffered a heart attack in September of 1996 which required five bypass grafts. At that point, she felt that her health began to decline and, after seeing multiple physicians, she began to see Dr. Tim Hayden, M.D., in November of 1998.[1] She continued to see Dr. Hayden for her ailments up to and continuing past her hearing before the ALJ. TR 223-236.

Dr. Hayden diagnosed Plaintiff with bursitis at this November visit and with osteopenia of the hips in April of 2000 and arthralgias in February of 2001.[2] In August 2001, Dr. Hayden noted that she had urinary stress incontinence and diagnosed Plaintiff with fibromyalgia two months later in October. Throughout the years of 2001 and 2002, Plaintiff visited Dr. Hayden on an almost monthly basis for complaints about abnormal heart activity, dizziness, urinary incontinence, and various aches, pains, and tenderness. Dr Hayden referred Plaintiff to Dr. Thomas Salvucci, D.O., in August of 2001 for a cardiac follow-up. In August of 2003, Dr. Hayden again referred the Plaintiff to Dr. Thomas Salvucci, D.O., after she experienced several episodes of a substernal burning feeling.[3] Dr. Salvucci diagnosed Plaintiff with coronary artery disease, hypertension, and a history of hyperlipidemia. He also ordered that Plaintiff undergo additional testing after which he concluded that she had severe diffuse disease in the right coronary artery which accounted for inferior wall ischemia and the left anterior descending

[1]Prior to seeing Dr. Hayden, Dr. Richard Winston, M.D., ordered a bone scan for Plaintiff from which he diagnosed her osteopenia of the hips.

[2]The osteopenia diagnosis was confirmed by DexaScan. On January 14, 2002, Dr. Hayden again diagnosed Plaintiff with osteopenia of the hips after reviewing the results of a second DexaScan.

[3]In his notes regarding the referral in 2003, Dr. Salvucci notes that he is seeing the Plaintiff for the first time. Nothing in the record indicates what became of the referral of August 2001.

artery was totally occluded at its origin. Of the five bypass grafts the Plaintiff received in 1996, the saphenous vein graft to the diagonal was totally occluded as was the sequential graft to the posterior descending artery and posterolateral branches.

At the time of the hearing before the ALJ, Plaintiff was on five to ten different medications for fibromyalgia, heart disease, status post having bypass surgery, osteopenia of the hips, depression, urinary stress incontinence, and anxiety disorder.[4] In a letter dated February 21, 2002, Dr. Hayden states that the Plaintiff has multiple health problems and that he believes she is unable to work "because of the fatigue and lethargy and pain" caused by those problems. TR 210. Dr. Hayden also signed a Medical Source Statement (Physical) on November 18, 2002 stating that Plaintiff could occasionally lift and carry ten (10) pounds and could stand or walk for a total of one hundred and sixty (160) minutes in an eight (8) hour workday, but only for twenty (20) minutes without interruption. Further, he found that Plaintiff could sit for a total of four (4) hours in an eight (8) hour workday but for only fifteen (15) minutes without interruption. Dr. Hayden also found that Plaintiff could not climb, stoop, crouch, kneel, or crawl. TR 272-274.

In addition to the medical records from Dr. Hayden, the administrative record also contains a consultive psychological evaluation by Patricia Williams, M.A., in concurrence with John Aday, Ed. D. TR 196-200. Upon examination, Plaintiff was observed to sit comfortably in her chair and exhibited no restlessness, tremors, or tics. She also ambulated with a steady gait. Her eye contact was good and she was polite, verbal, and cooperative. Plaintiff's affect was

[4]In Plaintiff's Exhibit 15E, Plaintiff has listed ten different medications that she was taking at the time of the hearing in 2003. TR 126-127. In Plaintiff's Exhibit 12E, she listed five medications that she was taking as of August 9, 2002. TR 118-121. In Dr. Hayden's statement of February 21, 2002, labeled as Exhibit 2F, Plaintiff is described as taking six different medications. TR 201.

broad and her mood was mildly dysthymic. During the examination, she was coherent, relevant, and there was no disorganization in her thought process. Plaintiff denied auditory or visual hallucinations and did not verbalize any grandiose or persecutory delusions. Her memory was intact for immediate, recent, and remote events and she was oriented as to time, place, and situation. She demonstrated good abstract reasoning in interpreting proverbs and appeared to function with adequate cognitive abilities and demonstrated adequate judgment.

The examiners found that Plaintiff met the diagnostic criteria for major depressive disorder and panic disorder without agoraphobia. They felt that Plaintiff's memory and ability to recall information were adequate for most pursuits but that her concentration and attention were impaired because of her depression. They opined that Plaintiff would have moderate problems adapting appropriately to social stressors at that time given her depression and panic disorder. TR 199-200.

Plaintiff was also examined by a consulting medical physician on April 30, 2002. The consulting physician noted that Plaintiff's musculoskeletal exam revealed only one painful trigger point, physical symptoms that are inconsistent with the American College of Rheumatology in their description of fibromyalgia.[5] She also noted that Plaintiff had full range

---

[5]The American College of Rheumatology's criteria for fibromyalgia are as follows:

1. History of widespread pain for three months.
   Pain is considered widespread when all of the following are present: Pain in the left and right side of the body, pain above and below the waist, and axial skeletal pain, meaning pain of the cervical, thoracic, or lumbar spine or the anterior chest. Shoulder and buttock pain is also considered as pain for the involved side.
2. Pain in eleven of the possible eighteen tender point sites on digital palpation.
   For a tender point to be considered "positive" the subject must state that the palpation was painful, and merely stating that the point of palpation was "tender" is not considered positive.

1990 Criteria for the Classification of Fibromyalgia,

of motion in her neck on all planes, experienced a fast but regular heart rhythm, and had no deficits in her straight away walk, tandem walk, one foot stand, or Romberg exam. The range of motion testing was intact at both shoulders, elbows, wrist, hands, hips, knees, and ankles without joint swelling, redness, or warmth. In regards to Plaintiff's complaints concerning stress urinary incontinence and osteopenia, the consulting physician noted that she was in stable condition and, in addition, Plaintiff did not show any evidence of limitations due to carpal tunnel syndrome.[6] Based upon her examination of Plaintiff, the consulting physician opined that Plaintiff could sit for at least six (6) hours in an eight (8) hour workday, walk or stand six (6) hours in an eight (8) hour workday, occasionally lift twenty (20) to twenty-five (25) pounds and frequently lift ten (10) pounds. TR 205.

Two other non-treating, non-examining physicians made an assessment of Plaintiff's physical residual functional capacity. TR 206-219. The first assessment, dated June 24, 2002, states that Plaintiff could occasionally lift and carry fifty (50) pounds, frequently lift and carry twenty-five (25) pounds, stand or walk for six (6) hours in an eight (8) hour workday, sit for six (6) hours in an eight (8) hour workday, frequently climb ramps, stairs, ladders, and scaffolds, and frequently balance, stoop, kneel, crouch, and crawl. The physician also indicated that Plaintiff's ability to push and/or pull was unlimited, other than as indicated for ability to lift and carry, and that she had no manipulative limitations.

The second assessment, dated September 6, 2002, states that Plaintiff could occasionally

---

http://www.rheumatology.org/publications/classification/fibromyalgia/fibro.asp?aud=mem.

[6]The consulting physician noted that Plaintiff's stress urinary incontinence symptoms have actually improved due to Plaintiff's use of Ditropan.

lift and carry fifty (50) pounds, frequently lift and carry twenty-five (25) pounds, stand or walk for six (6) hours in an eight (8) hour workday, sit for six (6) hours in an eight (8) hour workday, and had no postural or manipulative limitations. Additionally, the physician opined that Plaintiff's ability to push and/or pull was unlimited except as indicated for ability to lift and carry. At the end of the assessment, this particular physician also noted that there was no evidence of fibromyalgia. TR 219.

On two separate occasions, the Plaintiff was seen at the Humboldt General Hospital Emergency Room. She was treated for upper back pain in September of 2000 with an injection of Toradol and discharged in good condition. She returned to the Emergency Room in February of 2001 complaining of "chest tightness," "palpitations," and shortness of breath.[7] She was discharged in fair condition that same day.

Included in the Record is Plaintiff's Activities of Daily Living Questionnaire dated March 24, 2002. TR 77-84. She documents that she straightens her house, goes grocery shopping with her daughter every two to three weeks, reads, watches television, plays on her computer, writes poetry, and occasionally goes out with a friend to eat. She can stand in front of her stove to cook or her sink to wash dishes only for a very short time. Plaintiff goes to church activities sometimes and reported that she gets along "great" with others. In a second Activities of Daily Living Questionnaire dated August 9, 2002, however, Plaintiff states that she gets along with others "okay," goes shopping only once a month, had stopped attending church, and no longer went out with friends. TR 100-107. She must drive herself to the doctor or the store on

---

[7]Plaintiff was seen by Dr. Hayden two days after her emergency room visit in February, complaining that her heart was skipping some beats. He noted that her blood pressure was normal and her lungs were clear. TR 234.

occasion if her daughter is unavailable and states that her daughter and niece do the majority of the housework.

THE HEARING

At the hearing before the ALJ, the Plaintiff testified regarding her work history, her medical problems, and her daily living activities. TR 377-397. Ms. Nancy Miller, who was employed with the Madison County Sheriff's Department for thirty (30) years, testified as to Plaintiff's physical condition as did Plaintiff's friend and former co-worker, Ms. Julia Long. TR 397-404.

Plaintiff's testimony regarding her work history detailed her duties at the Sheriff's Department and at the Heritage Inn. She testified that she "started the (Sheriff's Department) Warrants Division and run [sic] the Warrants Division. And trained everybody that went into the Warrants Division." TR 381. While at the Sheriff's Department, Plaintiff testified that she would sit for six and one-half (6 ½) hours per day, walk or stand for one and one-half (1 ½) hours per day, and write almost all day. She also supervised two other employees for half of the day and would occasionally lift up to ten (10) pounds. During her time in the Warrants Division, Plaintiff stated that her work load steadily increased and that she finally retired due to constant pain that hampered her ability to concentrate and to cope with the demands of her job. After leaving the Sheriff's Department, Plaintiff went to work as a manager at the Heritage Inn. She testified that she would walk or stand for seven (7) to eight (8) hours, sit for two (2) hours, write for eight (8) hours, and climb, stoop, kneel, or crouch for an hour each day. While she was employed by the motel, Plaintiff testified that her "pain got unbearable" but she "couldn't seem to get any relief and because [she] had to be alert and supervise other people, [she] couldn't take

the necessary medication for the pain." TR 383. Additionally, Plaintiff stated that one of her duties was to inspect each room after the housekeepers had cleaned the rooms for the next guest but that her pain "got the point that [her] hips hurt so bad that [she] could not walk even half way of the motel" to complete her inspections. TR 383. When the motel was sold, the buyers "walked in and took over and that was it." TR 386.

As to her daily activities, Plaintiff testified that she lived with her daughter and granddaughter and that she occasionally went out to eat with a friend or a friend would come to visit. She stated that, in order to keep up with her housework, she will do a little bit and then sit down before getting up to do a little more. She washes dishes but testified that her granddaughter cleaned the house, vacuumed, and cleaned the bathtub. Plaintiff also responded to the ALJ's questions concerning her occasional attendance at church due to her inability to sit in once place for very long and his questions concerning her ability to drive. She told the ALJ that it was difficult for her to drive but that she sometimes had to drive herself to the doctor if her daughter was unable to do so.

Ms. Miller testified that she had known the Plaintiff for at least twenty (20) years during their time together as employees at the Sheriff's Department. She also testified that Plaintiff's job in the Warrant's Division was "very, very stressful" and that she had noticed how much pain Plaintiff seemed to be in and how the pain was affecting Plaintiff's ability to concentrate. TR 399. Ms. Miller's testimony concerning the Plaintiff on the day of the hearing was that Plaintiff "was worse than she had ever been...She just had trouble getting across the street and a lot of trouble getting up the steps." TR 400.

Ms. Julia Long testified after Ms. Miller concerning Plaintiff's employment at Heritage

Inn. She stated that she had known Plaintiff for three and one-half (3 ½) years and that during the time that Plaintiff worked as a manager at the motel, she observed that there were times Plaintiff had trouble getting up from a chair and walking from one end of the motel to the other.

THE ALJ'S DECISION

Using the five-step disability analysis,[8] the ALJ in this case found, at the first step and second step, that Plaintiff had not engaged in any substantial gainful employment since January 28, 2002 and that her osteopenia of the hips, diagnosis of fibromyalgia, and stress urinary incontinence meet the definition of "severe" under the Social Security Act. TR 17.

At the third step of the analysis, however, the ALJ found that Plaintiff's impairments did not, singly or in combination, meet or equal a listed impairment as set out in 20 C.F.R. Part 404, Subpart P, Appendix 1. TR 17. At the fourth step, the ALJ determined that Plaintiff's impairments restricted her to light work activity and thus she retained the residual functional capacity to return to her past relevant work as an office manager. TR 20-21.

STANDARD OF REVIEW

The standard of review for an appeal of this nature is limited in scope to whether the

---

[8]Entitlement to Social Security benefits is determined by a five-step sequential analysis set forth in the Social Security Regulations. 20 C.F.R. §§ 404.1520, 416.920. First, the claimant must not be engaged in substantial gainful activity for a period of not less than twelve months. 20 C.F.R. § 404.1520(c). Second, the claimant must suffer from a severe impairment. Id. Third, the ALJ must determine whether the impairment meets or equals the severity criteria set forth in the Listings of Impairments contained in the Social Security Regulations. 20 C.F.R. §§ 404.1520(d), 404.1525, 404.1526. If the impairment satisfies the criteria for a listed impairment, the claimant is considered to be disabled. If the claimant's impairment does not meet or equal a listed impairment, the ALJ must then undertake the fourth step and determine whether the claimant has the residual functional capacity to return to any past relevant work. 20 C.F.R. § 404.1520(e). If the ALJ finds that the claimant cannot perform past relevant work, then the fifth step requires the ALJ to determine whether the claimant can perform other work which exists in significant numbers in the national economy. 20 C.F.R. § 404.1520(f).

decision below is supported by substantial evidence and whether the Commissioner used the proper legal standards in making that decision. 42 U.S.C. § 405(g) (2005); *Barker v. Shalala*, 40 F.3d 789, 794 (6th Cir. 1994); *Abbot v. Sullivan*, 905 F.2d 918, 922 (6th Cir. 1990). Substantial evidence means more than a scintilla of evidence but is less than a preponderance of the evidence. It is such relevant evidence that a reasonable person might accept as adequate to support a conclusion. *Kirk v. Sec'y of Health & Human Servs.*, 667 F.2d 524, 535 (6th Cir. 1981) (quoting *Richardson v. Perales*, 402 U.S. 389, 401 (1971)). Under the substantial evidence standard, the reviewing court must examine the evidence in the record as a whole and take into account that which detracts from the decision that is under review. *Abbott*, 905 F.2d 923 (citing *Beavers v. Sec'y of Health, Educ. & Welfare*, 577 F.2d 383, 387 (6th Cir. 1978). It may not try the case *de novo*, resolve conflicts in the evidence, or decide questions of credibility. *Cutlip v. Sec'y of Health & Human Servs.*, 25 F.3d 284, 286 (6th Cir. 1994). If the court finds substantial evidence in the record to support the Commissioner's decision, the court must affirm that decision and "may not even inquire whether the record could support a decision the other way." *Barker*, 40 F.3d at 794 (quoting *Smith v. Sec'y of Health & Human Servs.*, 893 F.2d 106, 108 (6th Cir. 1989)).

ANALYSIS

Weight Given to Medical Reports and Records

Plaintiff alleged disability based upon osteopenia of the hips, fibromyalgia, stress urinary incontinence, heart disease, carpal tunnel syndrome, a nervous condition, anxiety attacks, and depression. She argues that the ALJ erred in rejecting the opinion of her treating physician, Dr. Hayden and instead relied upon the opinions of the non-treating physicians. The opinions of

treating physicians are generally entitled to greater weight than those of non-examining physicians. *Farris v. Sec'y of Health & Human Servs.*, 773 F.2d 85, 90 (6th Cir. 1985); 20 C.F.R. § 404.1527(d). Treating physician opinions, however, receive controlling weight only when they are supported by sufficient clinical findings and are consistent with the evidence. 20 C.F.R. § 404.1527(d)(2); *Cutlip*, 25 F.3d at 287. The lack of "detailed, clinical diagnostic evidence" can render a treating physician's opinion less creditworthy. *Walters v. Comm'r of Social Security*, 127 F.3d 525, 530 (6th Cir. 1997).

Dr. Hayden opined that Plaintiff suffered from numerous ailments, causing fatigue, lethargy, and pain to the point she was rendered incapable of working. The three other consulting physicians, however, did not concur with Dr. Hayden's assessment. Each found that Plaintiff could sit for six (6) hours in an eight (8) hour workday, stand or walk for six (six) hours in an eight (8) hour workday, and could frequently lift at least ten (10) pounds. Further, none of the three found that Plaintiff had any limitations due to carpal tunnel syndrome nor did she appear to need a cane to walk or stand. During Plaintiff's psychological evaluation, the examiners observed that she sat comfortably in her chair and ambulated with a steady gait. In addition, although Plaintiff still suffers from osteopenia of the hips, a second DexaScan ordered by Dr. Hayden and performed in June of 2002 shows that Plaintiff's condition had improved. In regards to Plaintiff's complaints of fibormyalgia, the consulting physician noted that Plaintiff's symptoms for fibromyalgia were inconsistent with the American College of Rheumatology's criteria as Plaintiff exhibited only one tender point instead of the required eleven[9] and one of the

[9]The physician also noted that Plaintiff was not sure if she had seen a rheumatologist or not for her fibromyalgia.

non-treating, non-examining physicians made the observations that there was no evidence Plaintiff suffered from fibromyalgia.

Plaintiff also points out that her cardiovascular situation alone constitutes a severe impairment due to multiple blockages in proximal coronary arteries and the bypass grafts thereto. Dr Hayden, however, does not set forth any limitations that Plaintiff is subjected to on account of her heart condition in his medical source statement and Plaintiff herself testified that she was not on any heart medication at the time of the hearing. In Dr Salvucci's treatment notes following Plaintiff's electrocardiogram and heart catheterization in October of 2003, he instructed her to avoid any heavy lifting and driving for two days but that she could gradually increase her activities after that. TR 330. He discharged her in stable and satisfactory condition and noted that she ambulated well post procedure. TR 229.

Based on the above, it does not appear that the ALJ rejected the records from Plaintiff's treating physician, Dr. Hayden. The ALJ duly noted Plaintiff's full course of treatment with Dr. Hayden. Rather, the ALJ found that Dr. Hayden's opinion that Plaintiff was unable to work was "inconsistent with the record as a whole, and is unsupported by his own medical records[10] . . . it appears that the assessment was based primarily on the claimant's subjective complaints of pain and limitation, rather than on objective clinical data." TR 20.

ALJ's Credibility Determination

The crux of Plaintiff's appeal as it relates to fibromyalgia and osteopenia is that the

[10]In his notes dated Thursday, June 20, 2002, Dr. Hayden notes that he advised Plaintiff to exercise. TR 225. He also documents that Plaintiff's vitals "actually look pretty good" and that her physical exam was unremarkable on the same day he wrote the aforementioned letter stating that Plaintiff was unable to work due to her many ailments. TR 201, 229.

diseases cause such extensive pain that they have disabled her and rendered her unable to work. She relies upon her own testimony, the testimony of her two co-workers, and upon the opinion of Dr. Hayden to support this contention. In the Sixth Circuit, "subjective complaints of pain may support a claim of disability." *Duncan v. Sec'y of Health & Human Services*, 801 F.2d 847, 852 (6th Cir. 1986). When a plaintiff asserts a disability due to pain, credibility determinations with respect to the claimant's complaints of pain are left to the ALJ. *Id*. An ALJ's credibility determination is given great deference because the fact finder has the unique opportunity to observe and evaluate the witness. *Walters*, 127 F.3d at 531. *Kirk*, 667 F.2d at 538. The ALJ's credibility determination, however, must be supported by substantial evidence. See, e.g. *Walters*, 127 F.3d at 531; *McGuire v. Comm'r of Social Sec*., 1999 U.S. App. LEXIS 5915, *17 (6th Cir. 1999) (unpublished).

In this case, the ALJ discounted Plaintiff's credibility because of inconsistencies in the record and between the allegations and the medical evidence. The ALJ set forth specific examples supporting his findings. For instance, Plaintiff testified that, although she was not using a cane, her doctor had advised her to use one and that she unable to walk or stand for more than ten (10) minutes without one. Dr. Hayden, however, did not indicate in any of his records or his medical source statement that Plaintiff needed to use a cane or that the use of a cane was one of Plaintiff's limitations. If fact, Dr. Hayden had advised Plaintiff to exercise. TR 225. In addition, Plaintiff was noted by others to walk without difficulty, her diagnosis of fibromyalgia is disputed by two other physicians, and the latest DexaScan shows that her osteopenia has improved. TR 198, 204-205, 219, 246.

Plaintiff also claimed that she had problems with concentration, anxiety, and depression.

The ALJ observed that her activities, such as going back and forth from her computer to her television, providing for her personal needs, handling her financial affairs, straightening her house, doing laundry, and washing dishes are activities "inconsistent with someone who claims severe problems" with the above stated conditions. TR 21. Further, while Plaintiff complained of panic attacks, she mentioned no panic-related restrictions and reported that she shops for groceries and attends church on occasion.

Residual Functional Capacity Determination

Plaintiff also argues that the ALJ's findings as to her residual functional capacity of a light range of work activity were unsupported by substantial evidence. The ALJ's findings echoed those contained in the examination report completed by the consulting medical physician. TR 202-205. The consulting physician found, and the ALJ agreed, that Plaintiff was subject to greater limitations than were suggested by the two non-treating, non-examining physicians. In determining that Plaintiff's residual functional capacity was restricted to a light range of work activity, and thus more limited than was set forth by the non-treating, non-examining physicians, the ALJ considered the consulting physician's assessment, the Plaintiff's testimony, and the medical evidence in the record.

As discussed above, the ALJ properly disregarded Dr. Hayden's findings as to Plaintiff's physical limitations and disabilities because his findings were based upon her subjective complaints and were not supported by objective clinical data. Thus, the ALJ properly relied upon the residual functional capacity assessment of the consulting physician. Further, the ALJ's determination of Plaintiff's residual functional capacity is supported by Plaintiff's own testimony that she performs some household chores, drives, shops for groceries, and occasionally

attends church.

Past Relevant Work

Plaintiff next contends that the ALJ erred in finding that her past relevant work was as an "office manager" in the Warrant's Division of the Madison County Sheriff's Department. Plaintiff's Brief insists that Plaintiff "was in charge of the Warrant's Division which was an infinitely more demanding job than that of any typical office manager" and that by failing to understand the demands of Plaintiff's employment, the ALJ could not reach a valid conclusion regarding Plaintiff's ability to return to past relevant work. Pl.'s Br. 14.

Plaintiff herself, however, reports that she was the office manager in the Warrant's Division in the Work History Report she filed with the Social Security Administration. TR 69. She also described the activities involved for this position and indicated that she lifted less than ten (10) pounds, walked or stood for one (1) hour in an eight (8) hour workday, sat for five (5) hours in an eight (8) hour workday, and knelt, crouched, and climbed an hour each workday. Based upon Plaintiff's own Work History Report and her testimony, the ALJ determined that Plaintiff's past relevant work fit within the definitional code of "office manager." This occupation, according to The Dictionary of Occupational Titles, is performed at a sedentary level of exertion. *The Dictionary of Occupational Titles*, #188.167-057 (4th Ed. 1994). Because Plaintiff's past relevant work as an office manager did not require the performance of any work-related activities that were precluded by her limitations and her impairments did not prevent her from performing her past relevant work, she is not disabled under the Social Security Act.

CONCLUSION

For the foregoing reasons, it is recommended that the ALJ's decision be **AFFIRMED**.

s/ S. Thomas Anderson
S. THOMAS ANDERSON
UNITED STATES MAGISTRATE JUDGE

Date: February 16, 2006.