PHYSICAL RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE

To: ______________________________

Re: ______________________________(Name of Patient)

______________________________(Social Security No.)

Please answer the following questions concerning your patient's impairments. *Attach all relevant treatment notes, radiologist reports, laboratory and test results that have not been provided previously to the Social Security Administration.*

1. Frequency and length of contact: ______________________________

2. Diagnoses: ______________________________

3. Prognosis: ______________________________

4. List your patient's *symptoms*, including pain, dizziness, fatigue, etc:

____

____

5. If your patient has pain, characterize the nature, location, frequency, precipitating factors, and severity of your patient's pain:

____

____

6. Identify the clinical findings and objective signs:

____

____

7. Describe the treatment and response including any side effects of medication that may have implications for working, e.g., drowsiness, dizziness, nausea, etc:

____

____

8. Have your patient's impairments lasted or can they be expected to last at least twelve months? __ Yes __ No

9. Is your patient a malingerer? __ Yes __ No

10. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? __ Yes __ No

11. Identify any psychological conditions affecting your patient's physical condition:

__Depression
__Somatoform disorder
__Psychological factors affecting physical condition
__Anxiety
__Personality disorder
__Other: ______________________

12. Are your patient's impairments (physical impairments plus any emotional impairments) *reasonably consistent* with the symptoms and functional limitations described in this evaluation? __ Yes __ No

If no, please explain: ____

13. How often during a typical workday is your patient's experience of pain or other symptoms severe enough to interfere with **attention and concentration** needed to perform even simple work tasks?

__Never __Rarely __Occasionally __Frequently __Constantly

For this and other questions on this form, "rarely" means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.

14. To what degree can your patient tolerate work stress?

__Incapable of even "low stress" jobs
__Moderate stress is okay
__Capable of low stress jobs
__Capable of high stress work

Please explain the reasons for your conclusion: ______________________________

15. As a result of your patient's work injury, estimate your patient's functional limitations if your patient were placed in a *competitive work situation.*

a. How many city blocks can your patient walk without rest or severe pain? ________

b. Please circle the hours and/or minutes that your patient can sit ***at one time,*** e.g., before needing to get up, etc.

Sit: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

c. Please circle the hours and/or minutes that your patient can stand ***at one time***, e.g., before needing to sit down, walk around, etc.

Stand: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

d. Please indicate how long your patient can sit and stand/walk *total in an 8-hour working day* (with normal breaks):

Sit	**Stand/walk**	
__	__	less than 2 hours
__	__	about 2 hours
__	__	about 4 hours
__	__	at least 6 hours

e. Does your patient need to include periods of walking around during an 8-hour working day? __ Yes __ No

1) If yes, approximately how *often* must your patient walk?

1 5 10 15 20 30 45 60 90
Minutes

2) How *long* must your patient walk each time?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Minutes

f. Does your patient need a job that permits shifting positions *at will* from sitting, standing or walking? __ Yes __ No

g. Will your patient sometimes need to take unscheduled breaks during an 8-hour working day? __ Yes __ No

If yes, 1) how *often* do you think this will happen? ______________
2) how *long* (on average) will your patient have to rest before returning to work? ______________

h. With prolonged sitting, should your patient's leg(s) be elevated? __ Yes __ No

If yes, 1) how *high* should the leg(s) be elevated? ______________
2) if your patient had a sedentary job, *what percentage of time* during an 8 hour working day should the leg(s) be elevated? ______________

i. While engaging in occasional standing/walking, must your patient use a cane or other assistive device? __ Yes __ No

j. How many pounds can your patient lift and carry in a competitive work situation?

	Never	**Rarely**	**Occasionally**	**Frequently**
Less than 10 lbs.		__	__	__
10 lbs.	__	__	__	__
20 lbs.	__	__	__	__
50 lbs.	__	__	__	__

k. How often can your patient perform the following activities?

	Never	Rarely	Occasionally	Frequently
Look down (sustained flexion of neck)	__	__	__	__
Turn head right or left	__	__	__	__
Look up	__	__	__	__
Hold head in static position	__	__	__	__

l. How often can your patient perform the following activities?

	Never	Rarely	Occasionally	Frequently
Twist	__	__	__	__
Stoop (bend)	__	__	__	__
Crouch/ squat	__	__	__	__
Climb ladders	__	__	__	__
Climb stairs	__	__	__	__

m. Does your patient have significant limitations with reaching, handling or fingering?

__ Yes __ No

If yes, please indicate the percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn <u>Twist Objects</u>	**FINGERS: Fine <u>Manipulations</u>**	**ARMS: Reaching <u>(incl. Overhead)</u>**
Right:	__%	__%	__ %
Left:	__%	__%	__ %

n. Are your patient's impairments likely to produce "good days" and "bad days"?

__ Yes __ No

If yes, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments or treatment:

- __ Never
- __ About one day per month
- __ About two days per month
- __ About three days per month
- __ About four days per month
- __ More than four days per month

16. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

____

____

______________________________ ______________________________

Date *Signature*

Printed/Typed Name: ______________________________

Address: ______________________________

____

____

7-28
3/02
§258.1