Residual Functional Capacity Questionnaire
HEADACHES

Patient: _____

DOB: _____

Physician completing this form: _____

Please complete the following questions regarding this patient's impairments and attach all supporting treatment notes, radiologist reports, laboratory and test results.

Symptoms & Diagnosis

Does your patient have headaches? ☐ Yes ☐ No

If yes, please characterize the following:

Location: _____

Frequency:_____

Duration: _____

Intensity/Severity:_____

What diagnoses has this patient received? _____

_____

Describe the patient's symptoms, such as pain, dizziness, fatigue, etc. _____

_____

_____

Does the patient have chronic pain/paresthesia? ☐ Yes ☐ No

Describe the patient's type of pain, location, frequency, precipitating factors, and severity. _____

_____

_____

Mark all positive objective signs exhibited by the patient:

☐ Concentration Issues	☐ Confusion	☐ Impaired appetites	☐ Gastritis
☐ Malaise	☐ Mood changes	☐ Nausea/Vomiting	☐ Photosensitivity
☐ Sleep Disturbances	☐ Tenderness	☐ Vertigo	☐ Visual Disturbances
☐ Weight Loss			

Mark any headache triggers for the patient:

☐ Alcohol	☐ Bright Light	☐ Exercise	☐ Foods: _____
☐ Hunger	☐ Lack of sleep	☐ Menstruation	☐ Noise
☐ Stress	☐ Strong odors	☐ Weather Changes	☐ Other:_____

Mark any situations that worsen the patient's headaches:

☐ Bright lights ☐ Coughing ☐ Movement ☐ Straining/Bowel movement
☐ Hunger ☐ Lack of sleep ☐ Menstruation ☐ Noise
☐ Stress ☐ Strong odors ☐ Weather Changes
☐ Other:_____

Mark any situations that improve the patient's headaches:

☐ Cold Pack ☐ Hot Pack ☐ Massage ☐ Finger pressure
☐ Lying in Dark Room ☐ Other: _____

What is the earliest date that the above description of limitations applies? _____

Have these symptoms lasted (or are they expected to last) twelve months or longer? ☐ Yes ☐ No

Are this patient's symptoms and functional limitations impacted by emotional factors? ☐ Yes ☐ No

If yes, please mark any known psychological conditions that affect this patient's pain:

☐ Depression ☐ Anxiety ☐ Somatoform disorder ☐ Personality disorder
☐ Other: _____

Are these physical and emotional impairments reasonably consistent with the patient's symptoms and functional limitations? ☐ Yes ☐ No

If no, please explain: _____

_____

Testing & Treatments

Mark all positive test results or positive clinical signs:

☐ CT scan ☐ EEG ☐ MRI ☐ X-ray

Identify any additional positive clinical findings and test results:_____

_____

_____

Mark all impairment(s) that could reasonably explain the patient's headaches:

☐ Anxiety/tension ☐ Cerebral hypoxia ☐ Cervical disc disease
☐ Head injury ☐ Hypertension ☐ Intracranial infection or tumor
☐ Migraine ☐ Seizure disorder ☐ Sinusitus
☐ Substance abuse ☐ Other:_____

Please list the patient's current medications:_____

_____

Please indicate the treatment type, start dates, and frequency: _____

_____

_____

What is the patient's prognosis? _____

Is this patient a malingerer? ☐ Yes ☐ No

Functional Work Limitations

When answering the following questions, please consider this patient's impairments and estimate his or her ability to work in a competitive work environment for an 8-hour shift with normal breaks.

Is this patient taking any medications with side effects that may affect his or her ability to work?

☐ Yes ☐ No

If yes, please list possible side effects. _____

_____

During times of headache, will the patient be precluded from performing even basic work activities?

☐ Yes ☐ No

If yes, please explain:_____

_____

Does the patient require unscheduled breaks?

☐ Yes ☐ No

If yes, how often? _____

During this time, this patient will need to ☐ lie down ☐ sit quietly for _____ minutes.

Do the patient's impairments require limited exposure to changes in the environment?

	No Exposure Restriction	Avoid Prolonged Exposure	Avoid Moderate Exposure	Avoid All Exposure
Extreme Cold	☐	☐	☐	☐
Extreme Heat	☐	☐	☐	☐
Fumes, odors, dusts, gasses	☐	☐	☐	☐
Humidity	☐	☐	☐	☐
Noise	☐	☐	☐	☐
Wetness	☐	☐	☐	☐
Others: _____	☐	☐	☐	☐
_____	☐	☐	☐	☐

Are this patient's impairments likely to produce "good days" and "bad days"?

☐ Yes ☐ No

If yes, please estimate, on 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

Please describe any other limitations that might affect this patient's ability to work at a regular job on a sustained basis, such as psychological issues, limited vision or hearing, or the inability to adjust to temperature, wetness, humidity, noise, dust, fumes, gases or hazards, etc.

_____

_____

_____

Please describe additional tests or clinical findings not described on this form that clarify the severity of the patient's impairments.

_____

_____

_____

Completed by:

_____ _____

Physican's Printed Name Physician's Signature

_____ _____

Address Date

_____

_____