Residual Functional Capacity Questionnaire
SEIZURE DISORDER

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

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._____

_____

_____

What type of seizures does your patient have? _____

Does the patient suffer from alcohol or drug abuse related seizures? ☐ Yes ☐ No
If yes, are they generalized or localized?_____

How long does a seizure typically last?_____

Does the patient lose consciousness? ☐ Yes ☐ No

How often does the patient have seizures? _____ per week _____ per month

What are the dates of the last three seizures? _____ _____ _____

Does the patient have warning of an impending seizure? ☐ Yes ☐ No

Does the patient experience precipitating factors to the onset of a seizure? ☐ Yes ☐ No
If yes, explain: _____
How much warning does the patient have before a seizure? _____minutes

Can your patient take safety precautions when he/she feels a seizure coming on? ☐ Yes ☐ No
If yes, explain: _____

What must others do during and immediately after the patient's seizure?
- ☐ Clear the area of hard or sharp objects
- ☐ Loosen tight clothing
- ☐ Put something soft under the head

☐ Remove glasses
☐ After seizure, turn patient on side to allow saliva to drain from mouth
☐ Other: _____

Please mark any post-seizure manifestations this patient experiences:
☐ Confusion ☐ Exhaustion ☐ Irritability
☐ Muscle strain ☐ Paranoia ☐ Severe headache
☐ Other: _____

How long do these manifestations last? _____

How are the patient's daily activities affected after a seizure? _____

_____

_____

Does your patient have a history of injury during a seizure? ☐ Yes ☐ No

Does your patient have a history of urinary incontinence during a seizure? ☐ Yes ☐ No

Does your patient have a history of fecal incontinence during a seizure? ☐ Yes ☐ No

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

Identify any positive clinical findings and test results: _____

_____

_____

Please list the patient's current medications: _____

_____

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

_____

_____

Does the patient regularly take his/her prescribed medications? ☐ Yes ☐ No
If no, does it make a difference in the frequency of seizures? ☐ Yes ☐ No

Please mark all side effects of the seizure medication this patient experiences:

☐ Coordination disturbance ☐ Difficulty focusing ☐ Dizziness
☐ Double vision ☐ Lack of alertness ☐ Lethargy
☐ Other: _____

Is it difficult to keep this patient's blood levels of anticonvulsant medication at less than therapeutic levels? ☐ Yes ☐ No

If yes, please explain:_____

_____

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.

How often do you expect this patient's pain or symptoms to interfere with the attention and concentration necessary to perform simple work tasks?

☐ Never
☐ Rarely (1% to 5% of an 8 hour working day)
☐ Occasionally (6% to 33% of an 8 hour working day)
☐ Frequently (34% to 66% of an 8 hour working day)
☐ Constantly

How well do you expect this patient to be able to tolerate work stress?

☐ Incapable of even "low stress" jobs
☐ Only capable of low stress jobs
☐ Moderate stress is okay
☐ Capable of high stress situations
Explain: _____

_____

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. _____

_____

Is it likely the patient's seizures would disrupt the work of co-workers? ☐ Yes ☐ No

Is it likely that this patient would need more supervision at work than an unimpaired worker? ☐ Yes ☐ No

Please mark the following activities that your patient is NOT ABLE to perform:

☐ Operate a motor vehicle ☐ Take a bus alone
☐ Use power machines ☐ Work at heights

Mark all of the following mental findings that have been documented about this patient by mental status examination or psychological testing.

☐ Behavior extremes ☐ Depression ☐ Irritability
☐ Memory problems ☐ Poor self-esteem ☐ Short attention span
☐ Social isolation ☐ Other: _____

Does this patient require unscheduled breaks?

☐ Yes ☐ No

If yes, how often? _____

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

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

_____

_____