Residual Functional Capacity Questionnaire
ARTHITIS

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. ________________

Please indicate all positive objective signs exhibited by the patient:

□ Abnormal gait □ Abnormal posture □ Atrophy □ Crepitus
□ Fatigue □ Fever □ Impaired appetite □ Impaired sleep
□ Joint Deformity □ Joint Instability □ Joint Redness □ Joint Swelling
□ Joint Tenderness □ Joint Warmth □ Malaise □ Positive straight leg test
□ Reduced grip strength □ Reflex changes □ Sensory changes
□ Spasms □ Trigger points □ Weakness □ Weight loss (Involuntary)
□ Other: ___________ □ Other: ___________ □ Other: ___________ □ Other: ___________

Does this patient experience decreased range of motion? □ Yes □ No
If yes, list affected joints: ___________________________________________

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

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: __________________________________
___________________________________________________________________________________
____________________________________________________________________________________

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: ____________________________________________________________
  ____________________________________________________________________________

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. ____________________________________________
  ____________________________________________________________________________

How far can this patient walk without rest or severe pain? ________________________________

How long can this patient sit comfortably at one time before needing to get up?
  Minutes:  0  5  10  15  20  30  45
Hours: 1 2 Longer than 2
What must the patient usually do after sitting this long?
☐ Stand ☐ Walk ☐ Lie Down ☐ Other: _____________________

How long can this patient stand comfortably at one time before needing to sit or walk around?
Minutes: 0 5 10 15 20 30 45
Hours: 1 2 Longer than 2
What must the patient usually do after sitting this long?
☐ Sit ☐ Walk ☐ Lie Down ☐ Other: _____________________

How long can this patient sit in an 8-hour working day?
☐ less than 2 hours
☐ about 2 hours
☐ about 4 hours
☐ at least 6 hours

How long can this patient stand and/or walk in an 8-hour working day?
☐ less than 2 hours
☐ about 2 hours
☐ about 4 hours
☐ at least 6 hours

Does this patient need to include periods of walking in an 8-hour working day?
☐ Yes ☐ No
If yes, how often? 5 10 15 20 30 45 60 90 minutes
For how many minutes? 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

Does this patient require a job that allows the opportunity to change between sitting, standing and walking at will? ☐ Yes ☐ No

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.

With prolonged sitting, should this patient's leg(s) be elevated?
☐ Yes ☐ No
If yes, for what percentage of time in an 8-hour day? ______%

During occasional standing/walking, does this patient require a cane or other assistive device?
☐ Yes ☐ No

How many pounds can this patient lift and carry?

<table>
<thead>
<tr>
<th>Weight</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 lbs.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>10 lbs.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>20 lbs.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>50 lbs.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

How often can your patient perform the following activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twist</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Stoop (bend)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Crouch</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Climb ladders</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>
Does this patient have significant limitations with repetitive reaching, handling or fingering?
☐ Yes  ☐ No
If yes, please indicate the percentage of time this patient can perform the following activities:
- Using hands to grasp, turn and twist objects Right _____% Left _____%
- Using fingers for fine manipulation Right _____% Left _____%
- Using arms to reach out and overhead Right _____% Left _____%

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 three days per month
☐ About one day per month  ☐ About four days per month
☐ About two 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:

Physician’s Printed Name ___________________________  Physician’s Signature ___________________________
____________________________________________________________________________________

Address ____________________________________________________  Date ___________________________