

Residual Functional Capacity Questionnaire ARTHRITIS

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:

- | | | | |
|--|--|--|---|
| <input type="checkbox"/> Abnormal gait | <input type="checkbox"/> Abnormal posture | <input type="checkbox"/> Atrophy | <input type="checkbox"/> Crepitus |
| <input type="checkbox"/> Fatigue | <input type="checkbox"/> Fever | <input type="checkbox"/> Impaired appetite | <input type="checkbox"/> Impaired sleep |
| <input type="checkbox"/> Joint Deformity | <input type="checkbox"/> Joint Instability | <input type="checkbox"/> Joint Redness | <input type="checkbox"/> Joint Swelling |
| <input type="checkbox"/> Joint Tenderness | <input type="checkbox"/> Joint Warmth | <input type="checkbox"/> Malaise | <input type="checkbox"/> Positive straight leg test |
| <input type="checkbox"/> Reduced grip strength | | <input type="checkbox"/> Reflex changes | <input type="checkbox"/> Sensory changes |
| <input type="checkbox"/> Spasms | <input type="checkbox"/> Trigger points | <input type="checkbox"/> Weakness | <input type="checkbox"/> Weight loss (Involuntary) |
| <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> Other: _____ | <input type="checkbox"/> 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?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How often can your patient perform the following activities?

	Never	Rarely	Occasionally	Frequently
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stoop (bend)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

