# Residual Functional Capacity Questionnaire
# CHRONIC FATIGUE SYNDROME

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 Chronic Fatigue Syndrome? ☐ Yes ☐ No

What other 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 of the following symptoms this patient exhibits concurrently, have persisted or recurred during six+ consecutive months, and did not predated the fatigue.

☐ Headaches of a new type, pattern or severity
☐ Malaise lasting more than 24 hours after physical exertion.
☐ Muscle pain
☐ Non-restful sleep
☐ Joint pain that affects multiple joints without swelling or redness
☐ Short term forgetfulness or lack of concentration that causes substantial reduction in occupational, educational, social or personal activities
☐ Sore throat
☐ Tender cervical or axillary lymph nodes

Does your patient have unexplained persistent or recurring chronic fatigue that is new or of definite onset, is not the result of ongoing exertion, and results in substantial reduction in previous levels of occupational, educational, social, or personal activities? ☐ Yes ☐ No

If yes, please describe the patient's history of fatigue. _____

_____

_____

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 of the following medical signs that have been clinically documented over a period of at least six consecutive months.

☐ Non-exudative pharyngitis
☐ Palpably swollen or tender lymph nodes
☐ Persistent reproducible muscle tenderness on repeated examinations, including positive tender points

Mark all of the following laboratory findings that apply to this patient.

☐ Elevated antibody titer to Epstein-Barr virus (EBV) capsid antigen equal to or greater than1:5120, or early antigen equal to or greater than 1:640
☐ Abnormal MRI brain scan
☐ Neurally mediated hypotension as shown by tilt table testing or other form of testing

List any other medically accepted laboratory findings that are consistent with the patient's symptoms,.

Identify any additional positive clinical findings and test results, such as abnormal exercise stress test or abnormal sleep studies: _____

_____

_____

Please list all diagnoses that have been excluded as the cause of this patient's fatigue, such as HIV-AIDS, malignancy, parasitic disease, psychiatric disease, rheumatoid arthritis, drug or alcohol addiction, medication side effects, etc.

_____

_____

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

☐ Anxiety ☐ Concentration limitations ☐ Comprehension problems
☐ Depression ☐ Information processing limitations ☐ Short term memory deficit
☐ Visual-spatial difficulties

List any other mental findings that suggest persisting neurocognitive impairment._____

_____

_____

Please list the patient's current medications: _____

_____

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

_____

_____

List all attempted treatments and medications, the patient's response, and exhibited side effects.

_____

_____

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 fatigue or other 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 require a job that allows the opportunity to change between sitting, standing and walking at will? ☐ Yes ☐ No

Might the patient require unscheduled breaks? ☐ Yes ☐ No

If yes, how many times? 1 2 3 4 5 6 7 8 9 10 >10

For how many minutes? <5 5 10 20 30 45 60 90 >90

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. | ☐ | ☐ | ☐ | ☐ |
| 10 lbs. | ☐ | ☐ | ☐ | ☐ |
| 20 lbs. | ☐ | ☐ | ☐ | ☐ |
| 50 lbs. | ☐ | ☐ | ☐ | ☐ |

How often can your patient perform the following activities?

| | Never | Rarely | Occasionally | Frequently |
|---|---|---|---|---|
| Twist | ☐ | ☐ | ☐ | ☐ |
| Stoop (bend) | ☐ | ☐ | ☐ | ☐ |
| Crouch | ☐ | ☐ | ☐ | ☐ |
| Climb ladders | ☐ | ☐ | ☐ | ☐ |
| Climb stairs | ☐ | ☐ | ☐ | ☐ |

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 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

_____

_____