# Residual Functional Capacity Questionnaire
## CROHN'S & COLITIS

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:
☐ Abdominal Distention   ☐ Abdominal Pain/Cramping   ☐ Anal Fissures   ☐ Bloody Diarrhea
☐ Bowel Obstruction   ☐ Chronic Diarrhea   ☐ Kidney problems   ☐ Fatigue
☐ Fever   ☐ Fistulas   ☐ Ineffective Straining   ☐ Loss of Appetite
☐ Malaise   ☐ Mucus in Stool   ☐ Peripheral Arthritis   ☐ Rectal Tenesmus
☐ Vomiting   ☐ Weight Loss   ☐ Other:_____

Does the patient exhibit episodes of symptoms? ☐ Yes    ☐ No
    If yes, please describe the nature, precipitating factors, severity, frequency and duration.

_____

_____

_____

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: _____

_____

_____

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

Does the patient require a job with ready access to a bathroom?     ☐Yes   ☐No

Might the patient's symptoms likely cause unscheduled bathroom breaks?     ☐ Yes     ☐ No

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

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

How much advance notice might this patient have? _____ minutes

Might the patient require additional unscheduled breaks to lie down, change soiled clothing, or rest at unpredictable times?     ☐ 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

For which symptoms?

☐ Chronic fatigue        ☐ Frequency/incontinence      ☐ Medication side effects

☐ Nausea/vomiting       ☐ Pain/paresthesia            ☐ Weakness

☐ Other: _____

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 | ☐ | ☐ | ☐ | ☐ |

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:

_____          _____
Physican's Printed Name                     Physician's Signature


_____          _____
Address                                     Date
_____

_____