Residual Functional Capacity Questionnaire
HEADACHES

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 headaches?  □ Yes  □ No
If yes, please characterize the following:

Location: ________________________________________________________________

Frequency: ______________________________________________________________

Duration: _________________________________________________________________

Intensity/Severity: __________________________________________________________

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. _____________

____________________________________________________________________________________

____________________________________________________________________________________

Mark all positive objective signs exhibited by the patient:

□ Concentration Issues  □ Confusion  □ Impaired appetites  □ Gastritis
□ Malaise  □ Mood changes  □ Nausea/Vomiting  □ Photosensitivity
□ Sleep Disturbances  □ Tenderness  □ Vertigo  □ Visual Disturbances
□ Weight Loss

Mark any headache triggers for the patient:

□ Alcohol  □ Bright Light  □ Exercise  □ Foods: ___________
□ Hunger  □ Lack of sleep  □ Menstruation  □ Noise
□ Stress  □ Strong odors  □ Weather Changes  □ Other: ___________
Mark any situations that worsen the patient’s headaches:
- Bright lights
- Coughing
- Movement
- Straining/Bowel movement
- Hunger
- Lack of sleep
- Menstruation
- Noise
- Stress
- Strong odors
- Weather Changes
- Other: ________________________________________________________________

Mark any situations that improve the patient’s headaches:
- Cold Pack
- Hot Pack
- Massage
- Finger pressure
- Lying in Dark Room
- Other: ________________________________________________________________

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 positive test results or positive clinical signs:
- CT scan
- EEG
- MRI
- X-ray

Identify any additional positive clinical findings and test results: ________________________________
____________________________________________________________________________________

Mark all impairment(s) that could reasonably explain the patient's headaches:
- Anxiety/tension
- Cerebral hypoxia
- Cervical disc disease
- Head injury
- Hypertension
- Intracranial infection or tumor
- Migraine
- Seizure disorder
- Sinusitus
- Substance abuse
- Other: ________________________________________________________________

Please list the patient's current medications: ________________________________________________
____________________________________________________________________________________

Please indicate the treatment type, start dates, and frequency: ________________________________
____________________________________________________________________________________
____________________________________________________________________________________

What is the patient's prognosis? _________________________________________________________

Is this patient a malingering? □ 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.

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. ________________________________________________________________

______________________________________________________

During times of headache, will the patient be precluded from performing even basic work activities?

☐ Yes  ☐ No

If yes, please explain: ________________________________________________________________

______________________________________________________

Does the patient require unscheduled breaks?

☐ Yes  ☐ No

If yes, how often? __________________________

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

Do the patient’s impairments require limited exposure to changes in the environment?

<table>
<thead>
<tr>
<th></th>
<th>No Exposure</th>
<th>Avoid Prolonged Exposure</th>
<th>Avoid Moderate Exposure</th>
<th>Avoid All Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme Cold</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Extreme Heat</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Fumes, odors, dusts, gasses</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Humidity</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Noise</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Wetness</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Others:</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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