Residual Functional Capacity Questionnaire
IRRITABLE BOWEL 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

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
☐ Sweatiness ☐ 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

RepresentMyself.com

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: ____

____

____

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: ____

____

RepresentMyself.com

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?

☐ Stand ☐ 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

____

____

RepresentMyself.com