Residual Functional Capacity Questionnaire
LUMBAR SPINE

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:
□ Abnormal posture   □ Atrophy   □ Chronic fatigue   □ Crepitus
□ Drops things   □ Joint Swelling   □ Joint Redness   □ Joint Warmth
□ Impaired appetite   □ Impaired sleep   □ Lack of coordination   □ Motor loss
□ Muscle spasm   □ Muscle weakness   □ Reduced grip strength   □ Reflex changes
□ Sensory changes   □ Spastic gait   □ Spastic gait   □ Swelling
□ Tenderness   □ Weight change
□ 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

Has the patient had a positive straight-leg raising test?  □ Yes    □ No
If yes, left at _____° and right at _____°

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 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.

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?

<table>
<thead>
<tr>
<th>Minutes:</th>
<th>0</th>
<th>5</th>
<th>10</th>
<th>15</th>
<th>20</th>
<th>30</th>
<th>45</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hours:</td>
<td>1</td>
<td>2</td>
<td>Longer than 2</td>
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</tbody>
</table>

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

- ☐ During this time, this patient will need to ☐ lie down ☐ rest head on high back chair ☐ other (describe) _________________________________ 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? ______%

How high? _________________________________

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?

<table>
<thead>
<tr>
<th>How much</th>
<th>Neve</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
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<tbody>
<tr>
<td>Less than 10 lbs.</td>
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<td>10 lbs.</td>
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<td>20 lbs.</td>
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<td>50 lbs.</td>
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</table>

How often can your patient perform the following activities?

<table>
<thead>
<tr>
<th>Activity</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
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</thead>
<tbody>
<tr>
<td>Twist</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Stoop (bend)</td>
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<td>☐</td>
<td>☐</td>
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<tr>
<td>Crouch</td>
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<td>☐</td>
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<tr>
<td>Climb ladders</td>
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<td>☐</td>
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<tr>
<td>Climb stairs</td>
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</table>
Does this patient have significant limitations with repetitive reaching, handling or fingerling?

☐ 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 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 ________________