

## 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:

- |  |  |  |   |
|--|--|--|---|
| <input type="checkbox"/> Abnormal posture  | <input type="checkbox"/> Atrophy         | <input type="checkbox"/> Chronic fatigue       | <input type="checkbox"/> Crepitus       |
| <input type="checkbox"/> Drops things      | <input type="checkbox"/> Joint Swelling  | <input type="checkbox"/> Joint Redness         | <input type="checkbox"/> Joint Warmth   |
| <input type="checkbox"/> Impaired appetite | <input type="checkbox"/> Impaired sleep  | <input type="checkbox"/> Lack of coordination  | <input type="checkbox"/> Motor loss     |
| <input type="checkbox"/> Muscle spasm      | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Reduced grip strength | <input type="checkbox"/> Reflex changes |
| <input type="checkbox"/> Sensory changes   | <input type="checkbox"/> Spastic gait    | <input type="checkbox"/> Spastic gait          | <input type="checkbox"/> Swelling       |
| <input type="checkbox"/> Tenderness        | <input type="checkbox"/> Weight change   |  |   |
| <input type="checkbox"/> 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:

- |                                       |                                  |  |   |
|---------------------------------------|----------------------------------|--|---|
| <input type="checkbox"/> Depression   | <input type="checkbox"/> Anxiety | <input type="checkbox"/> Somatoform disorder | <input type="checkbox"/> Personality disorder |
| <input type="checkbox"/> 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 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 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

If yes, how often? \_\_\_\_\_

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?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
10 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
20 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
50 lbs.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How often can your patient perform the following activities?

	Never	Rarely	Occasionally	Frequently
Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stoop (bend)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Climb stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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:

- |   |  |
|---|--|
| <input type="checkbox"/> Never                    | <input type="checkbox"/> About three days per month    |
| <input type="checkbox"/> About one day per month  | <input type="checkbox"/> About four days per month     |
| <input type="checkbox"/> About two days per month | <input type="checkbox"/> 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.

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Please describe additional tests or clinical findings not described on this form that clarify the severity of the patient's impairments.

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Completed by:

\_\_\_\_\_  
Physician's Printed Name

\_\_\_\_\_  
Physician's Signature

\_\_\_\_\_  
Address

\_\_\_\_\_  
Date

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