Residual Functional Capacity Questionnaire
PARKINSON’S DISEASE

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 this patient have from Parkinson’s Disease? ☐ Yes ☐ No

What other 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:

☐ Autonomic nervous dysfunction ☐ Blepharoclonus ☐ Bradykinesia

☐ Chronic fatigue ☐ Difficulty to start walking ☐ Falls

☐ Hypokinesia ☐ Difficulty to stand from seated ☐ Impaired gait

☐ Impaired control of distal musculature ☐ Muscular aches ☐ Postural instability

☐ Rigidity ☐ Saliva drooling ☐ Seborrhea

☐ Soft/poorly modulated voice ☐ Other: ___________________________________________

Identify any associated psychological problems/limitations:

☐ Anxiety ☐ Cognitive limitations ☐ Depression

☐ Impaired attention and concentration ☐ Impaired short term memory ☐ Personality change

☐ Reduced ability to attend to tasks ☐ Reduced ability to persist in tasks ☐ Social withdrawal

☐ Other: ___________________________________________________________________________

Does the patient have tremors? ☐ Yes ☐ No

If yes, please describe the nature and severity of the tremors and the parts of the body affected:

____________________________________________________________________________________

____________________________________________________________________________________

Are they enhanced by stress or fatigue? ☐ Yes ☐ No

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: _____________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

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: ________________________________________________________________
Mark the aspects of workplace stress that the patient most likely would unable to perform.

- Close interaction with co-workers/supervisors
- Detailed or complicated tasks
- Exposure to work hazards such as heights or machinery
- Fast-paced tasks, such as assembly lines
- Public contact
- Routine, repetitive tasks at consistent pace
- Strict deadlines
- Sustaining speech
- Other: ________________________________

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 this patient require unscheduled breaks?

- Yes
- No

If yes, how often? ________________________________ For how long? ________________________________

For which symptoms?

- Chronic fatigue
- Medication Side Effects
- Muscular Aches
- Tremor enhanced by stress
- Other: ______________________________

For which symptoms?

- Chronic fatigue
- Medication Side Effects
- Muscular Aches
- Tremor enhanced by stress
- Other: ______________________________
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? ______%

For which symptoms?

☐ Chronic fatigue  ☐ Medication Side Effects
☐ Muscular Aches  ☐ Tremor enhanced by stress
☐ Other:________________________________________________________

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>Weight</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 lbs.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>10 lbs.</td>
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<td>20 lbs.</td>
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<tr>
<td>50 lbs.</td>
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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>
</tr>
</thead>
<tbody>
<tr>
<td>Twist</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Stoop (bend)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Crouch</td>
<td>☐</td>
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<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Climb ladders</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Climb stairs</td>
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</tr>
</tbody>
</table>

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:

<table>
<thead>
<tr>
<th>Activity</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>Using hands to grasp, turn and twist objects</td>
<td>Right _____% Left _____%</td>
</tr>
<tr>
<td>Using fingers for fine manipulation</td>
<td>Right _____% Left _____%</td>
</tr>
<tr>
<td>Using arms to reach out and overhead</td>
<td>Right _____% Left _____%</td>
</tr>
</tbody>
</table>

For which symptoms?

☐ Bradykinesia  ☐ Fatigue  ☐ Impaired muscle control
☐ Medication Side Effects  ☐ Muscular Aches  ☐ Rigidity
☐ Tremor enhanced by stress  ☐ Other:________________________________________________________

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.

____________________________________________________________________________________

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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 ___________________________

____________________________________________________________________________________

____________________________________________________________________________________