Residual Functional Capacity Questionnaire

PHYSICAL RESIDUAL FUNCTION CAPACITY

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:
□ Decreased range of motion (list specific joints):
□ Crepitus □ Joint Deformity □ Joint Instability □ Joint Tenderness
□ Joint Swelling □ Joint Redness □ Joint Warmth □ Atrophy
□ Spasms □ Weakness □ Trigger points □ Reflex changes
□ Abnormal gait □ Abnormal posture □ Fatigue □ Fever
□ Impaired appetite □ Impaired sleep □ Malaise □ Positive straight leg test
□ Reduced grip strength □ Sensory changes □ Weight loss (Involuntary)

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:

____________________________________________________________________________________

____________________________________________________________________________________

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>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</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

If yes, how often? ________________________________

During this time, this patient will need to  
- [ ] lie down  
- [ ] sit quietly 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? ______%  

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>
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<tr>
<td>10 lbs.</td>
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<tr>
<td>20 lbs.</td>
<td>[ ]</td>
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<td>[ ]</td>
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<tr>
<td>50 lbs.</td>
<td>[ ]</td>
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</tbody>
</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>
</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>
</tr>
<tr>
<td>Crouch</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Climb ladders</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
<td>[ ]</td>
</tr>
<tr>
<td>Climb stairs</td>
<td>[ ]</td>
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</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:
- 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 one day per month
- About two days per month
- About three days per month
- About four 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 ____________________________