Residual Functional Capacity Questionnaire
REFLEX SYMPATHETIC DYSTROPHY (RSD)
COMPLEX REGIONAL PAIN SYNDROME (CRPS)

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 your patient suffer from RSD/ CRPS?  □ 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:

☐ Aching, burning, or searing pain initially localized to the site of injury
☐ Abnormal sensations of heat or cold
☐ Joint Tenderness
☐ Muscle atrophy
☐ Pain complaints that spread to other extremities
☐ Other: ______________________________________________________________________

☐ Chronic fatigue
☐ Joint Swelling
☐ Muscle pain
☐ Muscle spasm
☐ Pain complaints that spread to other extremities
☐ Other: ______________________________________________________________________

☐ Atrophy
☐ Joint Stiffness
☐ Muscle spasm
☐ Pain complaints that spread to other extremities
☐ Other: ______________________________________________________________________

☐ Increased sensitivity to touch
☐ Joint Warmth
☐ Muscle spasm
☐ Pain complaints that spread to other extremities
☐ Other: ______________________________________________________________________

☐ Restricted mobility
☐ Sleep Impairment
☐ Pain complaints that spread to other extremities
☐ Other: ______________________________________________________________________

Please indicate any associated psychological problems or limitations:

☐ Anxiety
☐ Impaired attention
☐ Personality change
☐ Other: ______________________________________________________________________

☐ Cognitive limitations
☐ Impaired concentration
☐ Reduced ability to attend to tasks
☐ Other: ______________________________________________________________________

☐ Depression
☐ Impaired short term memory
☐ Social withdrawal
☐ 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
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?  __________________________
What must the patient usually do after sitting this long?

<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>

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>
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<td>Hours</td>
<td>1</td>
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<td></td>
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</tbody>
</table>

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 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>Less than 10 lbs.</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>10 lbs.</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>20 lbs.</td>
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<td></td>
<td></td>
<td></td>
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<tr>
<td>50 lbs.</td>
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</table>

How often can your patient perform the following activities?

<table>
<thead>
<tr>
<th></th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
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<tbody>
<tr>
<td>Twist</td>
<td></td>
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<td></td>
<td></td>
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<tr>
<td>Stoop (bend)</td>
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<td></td>
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<tr>
<td>Crouch</td>
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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 _________________________________________________________________

____________________________________________________________________________________