Residual Functional Capacity Questionnaire
SPINAL

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 gait ☐ Abnormal posture ☐ Chronic fatigue ☐ Crepitus
☐ Drops things ☐ Impaired appetite ☐ Impaired sleep ☐ Lack of coordination
☐ Motor loss ☐ Muscle atrophy ☐ Muscle spasms ☐ Muscle weakness
☐ Reduced grip strength ☐ Reflex changes ☐ Sensory changes ☐ Spastic gait
☐ Swelling ☐ Tenderness ☐ Weight change ☐ Other: ___________

Does the patient exhibit severe headache pain associated with impairment of the cervical spine?

☐ Yes ☐ No

If yes, please characterize the nature, location and intensity/severity of the headaches:

_____________________________________________________________________________________

_____________________________________________________________________________________

Please indicate additional symptoms associated with the headaches:

☐ Exhaustion ☐ Impaired sleep ☐ Inability to concentrate
☐ Mental confusion ☐ Mood changes ☐ Nausea/vomiting
☐ Photosensitivity ☐ Vertigo ☐ Visual disturbance

How often do the headaches occur? ______ per week ______ per month

How long does a typical headache last? ______ minutes ______ hours
Please indicate actions that improve a headache:

- Cold pack
- Dark room
- Hot pack
- Lie down
- Quiet room
- Medication
- 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

**Clinical Signs & Treatments**

Does the patient have a positive straight-leg raising test both sitting and supine? □ Yes □ No

Does the patient have limited range of motion of the spine? □ Yes □ No

If yes, what is the range of motion for the following movements?

- Flexion ____ %
- Extension ____ %
- Lateral bending - right ____ %
- Lateral bending - left ____ %
- Other: ____________________________________________________________

If yes, what is the cervical range of motion for the following movements?

- Flexion ____ %
- Extension ____ %
- Lateral bending - right ____ %
- Lateral bending - left ____ %
- Other: ____________________________________________________________

Identify any additional positive clinical findings and test results: ________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Please list the patient’s current medications: ________________________________________________________________

____________________________________________________________________________________

Please indicate the treatment type, start dates, and frequency: __________________________________________________

____________________________________________________________________________________

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: ________________________________________________________________

____________________________________________________________________________________

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?

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

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></th>
<th>Never</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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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>Look Down</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Turn head right/left</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Look Up</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Head in static position</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Twist</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Stoop (bend)</td>
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<tr>
<td>Crouch</td>
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<tr>
<td>Climb ladders</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 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 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