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 ____% Lateral bending - right ____%
Extension____% Lateral bending - left ____%
Other: _____

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

Flexion ____% Lateral bending - right ____%
Extension____% 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 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 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?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.	☐	☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

How often can your patient perform the following activities?

	Never	Rarely	Occasionally	Frequently
Look Down	☐	☐	☐	☐
Turn head right/left	☐	☐	☐	☐
Look Up	☐	☐	☐	☐
Head in static position	☐	☐	☐	☐
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Climb ladders	☐	☐	☐	☐
Climb stairs	☐	☐	☐	☐

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:

_____ _____

Physican's Printed Name Physician's Signature

_____ _____

Address Date

_____

_____