Residual Functional Capacity Questionnaire
VESTIBULAR DISORDER

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:

☐ Balance disturbance	☐ Fatigue/exhaustion	☐ Malaise
☐ Mental confusion/inability to concentrate		☐ Mood changes
☐ Nausea/vomiting	☐ Photosensitivity	☐ Sensitivity to noise
☐ Tinnitus	☐ Vertigo	☐ Visual disturbances

☐ Other_____

Does the patient have a history of progressive hearing loss? ☐ Yes ☐ No

If yes, how was the hearing loss established? ☐ Audiometry ☐ Other: _____

Would it be difficult for your patient to understanding oral communications in an environment with constant background noise? ☐ Yes ☐ No

Does the patient's disturbed function of vestibular labyrinth demonstrated by caloric or other vestibular tests?

☐ Yes ☐ No

If no, explain how the absence of vestibular tests or a negative vestibular test affects the diagnosis and assessment of severity of the impairment: _____

How often does the patient experience Vestibular symptoms? _____ times per week _____ times per month

How long does an attack typically last? _____

Does the patient always have a warning of an impending attack? ☐ Yes ☐ No

If yes, how long is it between the warning and the onset of the attack? ____ minutes

Can the patient always take safety precautions when feeling an attack coming on? ☐ Yes ☐ No

Are there precipitating factors such as stress, exertion, sudden movement, certain kinds of light, computer monitors, etc.? ☐ Yes ☐ No

If yes, explain: _____

Does the patient exhibit positional vertigo? ☐ Yes ☐ No

If yes, please identify the postures or positions which are likely to cause vertigo:

☐ Bending forward at the waist ☐ Looking down ☐ Looking up
☐ Sitting to standing ☐ Turning head to left/right ☐ Walking
☐ Other: _____

What are post-attack manifestations?

☐ Confusion ☐ Exhaustion ☐ Paranoia
☐ Irritability ☐ Severe headache ☐ Other:_____

How long after an attack do these manifestations last? _____

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: _____

_____

Which aspects of workplace stress is your patient unable to tolerate?

- ☐ Public contact
- ☐ Routine, Repetitive Tasks at Consistent Pace
- ☐ Detailed or Complicated Tasks
- ☐ Strict Deadlines
- ☐ Close Interaction with Co-Workers/Supervisors
- ☐ Fast Paced Tasks, such as a production line
- ☐ Exposure to Work Hazards, such as heights or moving machinery
- ☐ 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 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

Might the patient require unscheduled breaks? ☐ Yes ☐ No

If yes, how many times? 1 2 3 4 5 6 7 8 9 10 >10

For how many minutes? <5 5 10 20 30 45 60 90 >90

For which symptoms?

- ☐ Chronic fatigue
- ☐ Medication side effects
- ☐ Nausea/vomiting
- ☐ Dizziness
- ☐ Tinnitus
- ☐ Other: _____

During occasional standing/walking, does this patient require a cane or other assistive device?

☐ Yes ☐ No

For which symptoms?

- ☐ Dizziness
- ☐ Other: _____

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
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐

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 _____%

What symptoms cause these limitations? _____

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:

_____ _____

Physican's Printed Name Physician's Signature

_____ _____

Address Date

_____

_____