PHYSICAL
RESIDUAL FUNCTIONAL CAPACITY
QUESTIONNAIRE

To: _____

Re: (Name of Patient): _____
(Social Security No.):_____
(Date of Birth):_____

Please answer the following questions concerning your patient's impairments. *Attach all relevant treatment notes, radiologist reports, laboratory and test results which have not been provided previously to the Social Security Administration.*

1. Nature, frequency and length of contact: _____

2. Diagnoses:

_____

_____

3. Prognosis:

_____

4. List your patient's *symptoms*, including pain, dizziness, fatigue, etc.:

_____

_____

5. If your patient has pain, characterize the nature, location, frequency, precipitating factors, and severity of your patient's pain:

_____

_____

_____

6. Identify the clinical findings and objective signs:

_____

_____

7. Describe the treatment and response including any side effects of medication which may have implications for working, e.g., drowsiness, dizziness, nausea, etc.:

_____

_____

_____

8. Have your patient's impairments lasted or can they be expected to last at least twelve months?

Yes No

9. Is your patient a malingerer?

Yes No

10. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?

Yes No

11. Identify any psychological conditions affecting your patient's physical condition:

___ Depression ____ Anxiety

___ Somatoform disorder ____ Psychological factors affecting

___ Personality disorder ____ Physical condition

Other: _____

_____

_____

12. Are your patient's impairments (physical impairments plus any emotional impairments) *reasonably consistent* with the symptoms and functional limitations described in this evaluation?

Yes No

If no, please explain:

_____

_____

13. How often is your patient's experience of pain or other symptoms severe enough to interfere with attention and concentration?

Never Seldom Often Frequently Constantly

14. To what degree is your patient limited in the ability to deal with work stress?

___ No limitation ___ Slight limitation ___ Moderate limitation

___ Marked limitation ___ Severe limitation

15. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a *competitive work situation:*

a. How many city blocks can your patient walk without rest? _____

b. Please circle the hours and/or minutes that your patient can *continuously* sit and stand *at one time*:

1. **Sit**:

0 5 10 15 20 30 45 — Minutes

1 2 More than 2 — Hours

2. **Stand**:

0 5 10 15 20 30 45 — Minutes

1 2 More than 2 — Hours

c. Please indicate how long your patient can sit and stand/walk *total in an 8 hour working day* (with normal breaks):

Sit	Stand/walk	
___	___	less than 2 hours
___	___	about 2 hours
___	___	about 4 hours
___	___	at least 6 hours

d. Does your patient need to include periods of walking around during an 8 hour working day? Yes No

1. If yes, approximately how *often* must your patient walk?

1 5 10 15 20 30 45 60 90
Minutes

2. How *long* must your patient walk each time?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Minutes

e. Does your patient need a job which permits shifting positions *at will* from sitting, standing or walking?
Yes No

f. Will your patient sometimes need to take unscheduled breaks during an 8 hour working day?

Yes No

If yes, (1) how *often* do you think this will happen? _____

(2) how *long* (on average) will your patient have to rest before returning to work? _____

g. With prolonged sitting, should your patient's leg(s) be elevated?

Yes No

If yes, (1) how *high* should the leg(s) be elevated? _____

(2) if your patient had a sedentary job, *what percentage of time* during an 8 hour working day should the leg(s) be elevated? _____%

h. While engaging in occasional standing/walking, must your patient use a cane or other assistive device?

Yes No

i. How many pounds can your patient lift and carry in a competitive work situation?

	Never	Occasionally	Frequently
less than 10 lbs.		___	___ ___
10 lbs.		___	___ ___
20 lbs.	___	___	___
50 lbs.	___	___	___

In an average 8 hour working day, "occasionally" means less than 1/3 of the working day; "frequently" means between 1/3 to 2/3 of the working day.

j. Does your patient have *significant limitations* in doing *repetitive* reaching, handling or fingering?

Yes No

If yes, please indicate the percentage of time during an 8 hour working day on a competitive job that your patient can use hands/fingers/arms for the following repetitive activities:

	HANDS: Grasp, Turn Twist Objects	FINGERS: Fine Manipulations	ARMS: Reaching (incl. Overhead)
Right:	%	%	%
Left:	%	%	%

k. Please state the percentage of time during an 8 hour working day that your patient can bend and twist at the waist.

Bend _____% Twist _____%

l. Are your patient's impairments likely to produce "good days" and "bad days"?

Yes No

m. On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?

___ Never ___ About twice a month

___ Less than once a month ___ About three times a month

___ About once a month ___ More than three times a month

16. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

_____

_____

_____

17. What is the earliest date that the description of symptoms *and limitations* in this questionnaire applies?

_____

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____

Thank you for your evaluation of this patient's impairment.