IRRITABLE BOWEL SYNDROME
RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE

To:

Re:

SSN: XXX-XX-

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

1. Frequency and length of contact: _____

2. Diagnoses: _____

   _____

3. Prognosis: _____

   _____

4. Identify your patient's symptoms:

___ Chronic diarrhea	___ Anal Fissures	___ Bloody Diarrhea
___ Nausea	___ Peripheral Arthritis	___ Sweatiness
___ Fever	___ Kidney problems	___ Weight loss
___ Malaise	___ Loss of appetite	___ Fatigue
___ Bowel Obstruction	___ Mucus in stool	___ Vomiting
___ Fistulas	___ Abdominal pain and cramping	

   ___ Ineffective straining at stool (rectal tenesmus)

   ___ Other: _____

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

   _____

   _____

6. If aspects of your patient's impairment are episodic, describe the nature, precipitating factors, severity, frequency and duration of the episodic aspects: _____

   _____

   _____

7. Identify the clinical findings and objective signs: _____

   _____

   _____

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

_____

_____

9. Have your patient's impairments lasted or can they be expected to last at least twelve months?
___ 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
___ Personality disorder ___ Psychological factors affecting 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 during a typical workday is your patient's experience of pain or other symptoms severe enough to interfere with **attention and concentration** needed to perform even simple work tasks?

___ Never ___ Rarely ___ Occasionally ___ Frequently ___ Constantly

For this and other questions on this form, **"rarely"** means 1% to 5% of an 8-hour working day **"occasionally"** means 6% to 33% of an 8-hour working day; **"frequently"** means 34% to 66% of an 8-hour working day.

14. To what degree can your patient tolerate work stress?
___ Incapable of even "low stress" jobs ___ Capable of low stress jobs
___ Moderate stress is okay ___ Capable of high stress work
Please explain the reasons for your conclusions: _____

_____

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? _____

b. Please circle the hours and/or minutes that your patient can sit ***at one time,*** e.g., before needing to get up, etc.

Sit: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

c. Please circle the hours and / or minutes that your patient can stand ***at one time***, e.g., before needing to sit down, walk around, etc.

Stand: 0 5 10 15 20 30 45 (Minutes) 1 2 More than 2 (Hours)

d. 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

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

f. Does your patient need a job that permits ready access to a restroom?

___ Yes ___ No

g. Will your patient sometimes need to take unscheduled restroom breaks during an 8 hour working day? ___ Yes ___ No

1. If yes, how often do you think this will happen? _____
2. How long will your patient be away from the work station for an average unscheduled restroom break? _____
3. How much advance notice does your patient have of the need for a restroom break?

_____

h. Will your patient also sometimes need to lie down or rest at unpredictable intervals during an 8-hour working day? ___ Yes ___ No

1. If yes, how *often* do you think this will happen? _____
2. How long (on average) will your patient have to rest before returning to work?

_____

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

j. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Twist	___	___	___	___
Stoop (bend)	___	___	___	___
Crouch/ squat	___	___	___	___
Climb ladders	___	___	___	___
Climb stairs	___	___	___	___

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

___ Yes ___ No

1. If yes, please estimate, on the 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

16. Please describe any other limitations (such as limitations using hands, arms, fingers, 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: _____

_____

_____

_____

Date: _____ Signature: _____

Printed/Typed Name: _____

Address: _____

_____

_____