Lower Extremity
RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE

Dr:

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 the ***clinical findings***, laboratory and test results that show your patient's medical impairments:

_____

_____

_____

5. Identify all of your patient's ***symptoms***, including pain, insomnia, fatigue, etc.:

_____

_____

6. If your patient has **pain**:

a. Characterize the nature, location, radiation, frequency and the precipitating factors:

_____

_____

_____

b. Characterize the **severity** of your patient's chronic pain/paresthesia:

- ☐ **mild**(pain level 0-3 up to 2 hours a day)
- ☐ **moderate**(pain level 4-6 up to 4-6 hours a day)
- ☐ **severe**(pain level of 7 and above constantly throughout the day)

7. Identify any positive **Lower Extremity** objective signs:

a. ____ Reduced range of motion: _____

Description: _____

_____

___ Positive straight leg raising test:	___ Swelling
___ Left at_____° Right at_____°	___ Muscle spasm
___ Abnormal gait	___ Muscle atrophy
___ Sensory loss/Neuropathy	___ Muscle weakness
___ Reflex changes	___ Impaired appetite or gastritis
___ Tenderness	___ Impaired sleep
___ Crepitus	

Other signs: _____

8. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? __ Yes __ No

9. 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:_____

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.

10. 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

a.. If your patient was placed in a competitive job, identify those aspects of **workplace stress** that your patient would be **unable to perform** or be exposed to:

- ☐ public contact
- ☐ routine, repetitive tasks at consistent pace
- ☐ detailed or complicated tasks
- ☐ strict deadlines
- ☐ close interaction with coworkers/supervisors
- ☐ fast paced tasks (e.g., production line)
- ☐ exposure to work hazards (e.g., heights or moving machinery)
- ☐ other:_____

11. Identify the side effects of any medication that may have implications for working, e.g., dizziness, drowsiness, stomach upset, etc.:

_____

_____

12. Have your patient's impairments lasted or can they be expected to last at least twelve months? __ Yes __ No

13. **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 or severe pain? _____

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)

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)

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

e. 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

f. Does your patient need a job that permits shifting positions *at will* from sitting, standing or walking? __Yes __No

g. 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? _____

h. 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? _____%

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

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

	Never	**Rarely**	**Occasionally**	**Frequently**
Less than 10 lbs.	—	—	—	—
10 lbs.	—	—	—	—
20 lbs.	—	—	—	—
50 lbs.	—	—	—	—

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

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

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

__Yes __No

If yes, will your patient likely to be absent from work 3 or more days per month:
__ Yes __ No

14. Have your patient's impairments lasted or can they be expected to last at least twelve months? ☐ Yes ☐ No

15. **What is the earliest date that the description of *symptoms and limitation* in this questionnaire applies?** _____

16. Please attach an additional page to 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.

_____ _____

Date *Signature*

Printed/Typed Name:

_____

Address: _____

_____