LUMBAR SPINE
RESIDUAL FUNCTIONAL CAPACITY
QUESTIONNAIRE

To: 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, precipitating factors, and severity of your patient's pain:

_____

_____

b. Identify any positive objective signs:

__ Reduced range of motion: _____
Description:

_____

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

Other signs: _____

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

8. 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:_____

9. 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.

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

_____

_____

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

12. As a result of 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. Does your patient have significant limitations with reaching, handling or fingering?

__Yes __No

If yes, please indicate the hours during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

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

m. 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

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

14. 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: _____

_____

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