MULTIPLE SCLEROSIS
RESIDUAL FUNCTIONAL CAPACITY
QUESTIONNAIRE

To: ______________________________

Re: ______________________________ (Name of Patient)

______________________________ (Social Security No.)

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. Frequency and length of contact:____________________

2. Does your patient have multiple sclerosis? __ Yes __ No

   If yes, how was this diagnosis made?________________

3. Prognosis:____

4. Identify all of your patient's symptoms:

__	fatigue	__	pain
__	balance problems	__	difficulty remembering
__	poor coordination	__	depression
__	weakness	__	emotional ability
__	paralysis	__	difficulty solving problems
__	unstable walking	__	problems with judgment
__	numbness, tingling or other	__	double or blurred vision/partial
__	sensory disturbance	__	or complete blindness
__	increased muscle tension	__	involuntary rapid eye movement
__	(spasticity)	__	shaking tremor
__	bladder problems	__	speech/communication
__	bowel problems	__	difficulties
__	sensitivity to heat	__	

__ other:____

5. Does your patient have significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movement or gait and station? __ Yes __ No

   If yes, please describe the degree of interference with locomotion and/or interference with the use of fingers, hands and arms:____

   ____

6. Does your patient have significant reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination, resulting from neurological dysfunction in areas of the central nervous system known to be pathologically involved by the multiple sclerosis process? __ Yes __ No

   If yes, describe the degree of exercise and the severity of the resulting muscle weakness:__________________________

   ____

7. a. During the past year what are the approximate dates of exacerbations of multiple sclerosis?______________

   ____

   ____

   b. Of the exacerbations listed above, circle the ones that would prevent *any* work for *more than one month.*

8. Does your patient complain of a type of fatigue that is best described as lassitude rather than fatigue of motor function? __ Yes __ No

   If yes, is this kind of fatigue complaint typical of M.S. patients? __ Yes __ No

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

10. 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:______________________________

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

__ Never __ Seldom __ Often __ Frequently __ Constantly

12. 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 conclusion:________

____

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

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

____

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 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. How long can your patient 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 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) On average, how long 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

For the next two questions, "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.

i. 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.	[ ]	[ ]	[ ]	[ ]

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

	Never	Rarely	Occasionally	Frequently
Twist	[ ]	[ ]	[ ]	[ ]
Stoop (bend)	[ ]	[ ]	[ ]	[ ]
Crouch	[ ]	[ ]	[ ]	[ ]
Climb ladders	[ ]	[ ]	[ ]	[ ]
Climb stairs	[ ]	[ ]	[ ]	[ ]

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

__ Yes __ No

If yes, please indicate the 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:	___ Hr	___ Hr	___ Hr
Left:	___ Hr	___ Hr	___ Hr

l. State the degree to which your patient should avoid the following:

ENVIRONMENTAL RESTRICTIONS:	NO RESTRICTION	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Extreme cold				
Extreme heat				
Wetness				
Humidity				
Noise				
Fumes, odors, dusts, gases, poor ventilation, etc.				
Hazards (machinery, heights, etc.)				

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

16. Please attach additional page to describe any other limitations that would affect your patient's ability to work at a regular job on a sustained basis.

____________________ ____________________

Date Signature

Printed/Typed Name: ____________________

Address: ____________________

____