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

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

___ Depression ___ Anxiety

___ Somatoform disorder ___ Personality disorder

___ Psychological factors affecting ___ Physical condition

___ Other: _____

11. 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: _____

_____

12. 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.

13. 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: _____

_____

14. 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)

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 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 2 3 4 5 6 7 8 9 10
Times

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

1 5 10 15 20 30 45 60 90
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

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? _____

_____

h. With prolonged sitting, should your patient's leg(s) be elevated?
___ Yes ___ No

1. If yes, 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
Look down (sustained flexion of neck)	___	___	___	___
Turn head right or left	___	___	___	___
Look up	___	___	___	___
Hold head in static position	___	___	___	___

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

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

m. Does your patient have significant limitations with reaching, handling or fingering?
___Yes ___No

If yes, please indicate the time 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**

n. 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

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

_____

_____

16. Please attach an additional page to describe any other limitations (such as psychological imitations, 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: _____

_____

_____