UPPER EXTREMITIES

RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE

To: Dr.

Re:

SSN:

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. Does your patient have chronic pain/paresthesia? __ Yes __ No

   A. If yes, describe the nature, location, frequency, precipitating factors, and severity of your patient's pain/paresthesia:

   _____

   _____

   B. Identify signs, findings, and associated symptoms of your patient's impairments:

☐ Tenderness	☐ Weight change	☐ Reflex changes
☐ Crepitus	☐ Sensory changes	☐ Swelling
☐ Muscle spasm	☐ Impaired sleep	☐ Atrophy
☐ Muscle weakness	☐ Impaired appetite	☐ Motor loss
☐ Chronic fatigue	☐ Lack of coordination	☐ Drops things
☐ Spastic gait	☐ Abnormal posture	☐ Reduced grip strength

   Other:

   _____

C. Does your patient have significant limitation of motion?

__ Yes __ No

If yes, please indicate cervical range of motion (ROM):

Extension	_____%	Flexion	_____%
Left rotation	_____%	Right rotation	_____%
Left lateral bending	_____%	Right lateral bending	_____%

5. 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

6. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a *competitive work situation* g. Will your patient sometimes need to take unscheduled breaks during an 8-hour working day? __ Yes __ No

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

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

b. 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**

7. 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

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

9. Please 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: