ARTHRITIS
RESIDUAL FUNCTIONAL CAPACITY
QUESTIONNAIRE

To: _____

Re: _____ (Name of Patient)

_XXX - XX -_____ (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. Nature, frequency and length of contact: _____

_____

2. Diagnoses: _____

_____

3. Prognosis: _____

4. Identify all of 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 any positive objective signs:

[ ] Reduced range of motion:
Joints affected: _____
_____

[ ] Joint warmth
[ ] Joint deformity
[ ] Joint instability
[ ] Reduced grip strength
[ ] Sensory changes
[ ] Reflex changes
[ ] Impaired sleep
[ ] Weight change
[ ] Impaired appetite
[ ] Abnormal posture
[ ] Tenderness
[ ] Crepitus

[ ] Trigger points

[ ] Redness
[ ] Swelling
[ ] Muscle spasm
[ ] Muscle weakness
[ ] Muscle atrophy
[ ] Abnormal gait
[ ] Positive straight leg raising test

Other clinical findings: _____

7. Is your patient a malingerer? __ Yes ___ No

8. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?

__ Yes ___ No

9. How often is your patient's experience of pain severe enough to interfere with attention and concentration?

__ Never __ Seldom __ Often __ Frequently __ Constantly

10. Identify any psychological conditions affecting pain:

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

_____

14. Have your patient's impairments lasted or can they be expected to last at least twelve months?

__ Yes ___ No

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 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 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 which 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?

_____

3) on such a break, will your patient need to [ ] lie down or [ ] sit quietly?

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

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.

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	__	__	__	__
Climb ladders	__	__	__	__
Climb stairs	__	__	__	__

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

__ Yes ___ No

If yes, please indicate the percentage of 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:	%	%	%
Left:	%	%	%

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

__ Yes ___ No

If yes, please estimate, on the average, how often your patient is likely to be absent from work as result of the impairments or treatment:

[ ] Never
[ ] About one day per month
[ ] About two days per month
[ ] About three days per month
[ ] About four days per month
[ ] More than four days per month

16. 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 ability to work at a regular job on a sustained basis:

_____

_____

_____ _____

Date *Signature*

Please return to:
Driscoll Salazar Disability Group
8280 Aspen Ave. Ste 155
Rancho Cucamonga, CA 91730
P: 909-736-8559
F: 909-736-0405

Printed/Typed Name: _____

Address: _____

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