FIBROMYALGIA
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. Does your patient meet the American College of Rheumatology criteria for fibromyalgia?

☐ Yes ☐ No

3. Other diagnoses:

_____

4. Prognosis:

_____

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

☐ Yes ☐ No

6. Identify the *clinical findings*, laboratory and test results which show your patient's medical impairments:

_____

_____

_____

_____

7. Identify all of your patient's symptoms:

- ☐ Multiple tender points
- ☐ Nonrestorative sleep
- ☐ Chronic fatigue
- ☐ Morning stiffness
- ☐ Muscle weakness
- ☐ Subjective swelling
- ☐ Irritable Bowel Syndrome
- ☐ Frequent, severe headaches
- ☐ Female Urethral Syndrome
- ☐ Premenstrual Syndrome (PMS)
- ☐ Vestibular dysfunction
- ☐ Temporomandibular Joint Dysfunction (TMJ)
- ☐ Numbness and tingling
- ☐ Sicca symptoms
- ☐ Raynaud's Phenomenon
- ☐ Dysmenorrhea
- ☐ Breathlessness
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Depression
- ☐ Mitral Valve Prolapse
- ☐ Hypothyroidism
- ☐ Carpal Tunnel Syndrome
- ☐ Chronic Fatigue Syndrome

8. Is your patient a malingerer?

☐ Yes ☐ No

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

☐ Yes ☐ No

10. If your patient has pain:

a. Identify the location of pain including, where appropriate, an indication of right or left side or bilateral areas affected:

	RIGHT	LEFT	BILATERAL
__ Lumbosacral spine	__	__	__
__ Cervical spine	__	__	__
__ Thoracic spine	__	__	__
__ Chest	__	__	__
__ Shoulders	__	__	__
__ Arms	__	__	__
__ Hands/fingers	__	__	__
__ Hips	__	__	__
__ Legs	__	__	__
__ Knees/ankles/feet	__	__	__

b. Describe the nature, frequency, and severity of your patient's pain:

_____

_____

c. Identify any factors that precipitate pain:

__ Changing weather __ Fatigue __ Movement/Overuse __ Cold
__ Stress __ Hormonal Changes __ Static Position

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

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

_____

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

If yes, approximately how *often* must your patient walk?

1 5 10 15 20 30 45 60 90
Minutes

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. While engaging in occasional standing/walking, must your patient use a cane or other assistive device?

☐ Yes ☐ No

h. Will your patient sometimes need to take unscheduled breaks during an 8-hour working day?

☐ Yes ☐ No

If yes, How *often* do you think this will happen? _____
How *long* (on average) will your patient have to rest before returning to work? _____
While on such a break, will your patient need to:
___ lie down ___ sit quietly ___ neither

i. With prolonged sitting, should your patient's leg(s) be elevated?

☐ Yes ☐ No

If yes, How *high* should the leg(s) be elevated? _____

If your patient had a sedentary job, *what percentage of time* during an 8-hour working day should the leg(s) be elevated? _____%

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. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Look down (sustained flexion of neck)	___	___	___	___
Turn head left or right	___	___	___	___
Look up	___	___	___	___
Hold head in static position	___	___	___	___

m. 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 (inc. Overhead)**
Right:	%	%	%
Left:	%	%	%

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

☐ Yes ☐No

If yes, please estimate, on the average, how many days per month your patient is likely to be absent from work as a 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 attach an 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

Print/Type Name: _____

Address: _____

Please return to:
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