

PHYSICAL 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 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. Is your patient a malingerer? Yes No
10. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? Yes No

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

- | | |
|---|---|
| <input type="checkbox"/> Depression | <input type="checkbox"/> Anxiety |
| <input type="checkbox"/> Somatoform disorder | <input type="checkbox"/> Personality disorder |
| <input type="checkbox"/> Psychological factors affecting physical condition | <input type="checkbox"/> Other: _____ |

12. 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: _____

13. 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.

14. To what degree can your patient tolerate work stress?

- | | |
|--|--|
| <input type="checkbox"/> Incapable of even "low stress" jobs | <input type="checkbox"/> Capable of low stress jobs |
| <input type="checkbox"/> Moderate stress is okay | <input type="checkbox"/> Capable of high stress work |

Please explain the reasons for your conclusion: _____

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: | <u>0</u> <u>5</u> <u>10</u> <u>15</u> <u>20</u> <u>30</u> <u>45</u> | <u>1</u> <u>2</u> <u>More than 2</u> |
| | Minutes | 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: | <u>0</u> <u>5</u> <u>10</u> <u>15</u> <u>20</u> <u>30</u> <u>45</u> | <u>1</u> <u>2</u> <u>More than 2</u> |
| | Minutes | 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 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

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? _____

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

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 percentage of time during an 8-hour working day that your patient can use hands/fingers/arms for the following activities:

	HANDS: Grasp, Turn <u>Twist Objects</u>	FINGERS: Fine <u>Manipulations</u>	ARMS: Reaching <u>(incl. Overhead)</u>
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:

- | | |
|---|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> About three days per month |
| <input type="checkbox"/> About one day per month | <input type="checkbox"/> About four days per month |
| <input type="checkbox"/> About two days per month | <input type="checkbox"/> 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 patient's ability to work at a regular job on a sustained basis:

Date

Signature

Printed/Typed Name: _____

Address: _____

Please return to:
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Rancho Cucamonga, CA 91730
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