SEIZURES
RESIDUAL FUNCTIONAL CAPACITY
QUESTIONNAIRE

To: _____

Re: _____ (Name of Patient)

XXX - XX - _____ (Social Security No.)

Please answer the following questions concerning your patient's seizures. *Attach all relevant treatment notes, laboratory and test results that have not been provided previously to the Social Security Administration.*

1. Frequency and length of contact: _____

   _____

2. Diagnoses: _____

   _____

3. Does your patient have seizures? __Yes __No

4. What type of seizures does your patient have? _____

5. Are the seizures __ generalized __ localized?

6. Is there loss of consciousness? __Yes __No

7. a. What is the average frequency of your patient's seizures?

   _____ per week _____per month

   b. What are the dates of the last three seizures?

   (1) _____ (2) _____ (3) _____

8. How long does a typical seizure last? _____

9. Does your patient always have a warning of an impending seizure? __Yes __No

   If yes, how long is it between the warning and the onset of the seizure?_____minutes

   Can your patient always take safety precautions when he/she feels a seizure coming on?

   __Yes __No

10. Do seizures occur at a particular time of the day? __Yes __No

    If yes, explain when seizures occur: _____

11. Are there precipitating factors such as stress, exertion? __Yes __No

    If yes, explain: _____

12. What sort of action must others take during and immediately after your patient's seizure?

    Check those that apply:

    __ Put something soft under the head
    __ Remove glasses
    __ Loosen tight clothing
    __ Clear the area of hard or sharp objects
    __ After seizure, turn patient on side to allow saliva to drain from mouth
    __ Other: _____

13. What are the postictal manifestations?

    Check those that apply:

    __ Confusion
    __ Exhaustion
    __ Irritability
    __ Other: _____
    __ Severe headache
    __ Muscle strain
    __ Paranoia

14. How long after a seizure do these postictal manifestations last? _____

15. Describe the degree to which having a seizure interferes with your patient's daily activities following a seizure:

    _____

    _____

16. Does your patient have a history of injury during a seizure? __Yes __No

17. Does your patient have a history of fecal or urinary incontinence during a seizure?

18. Type of medication and response: _____

    _____

19. Is your patient compliant with taking medication? __ Yes __ No

    If no, does it make a difference in the frequency of seizures? __ Yes __ No

20. Does your patient suffer any side effects of seizure medication?

Check those that apply:

__ Dizziness
__ Eye focusing problems
__ Lethargy
__ Other: _____

Double vision
Coordination disturbance
Lack of alertness

21. If your patient's blood levels of anticonvulsant medication have recently been at less than therapeutic levels, please explain why there has been difficulty controlling blood levels.

_____

_____

_____

22. Does your patient suffer from ethanol related seizures or ethanol/other drug abuse? __Yes __No

23. Are your patient's seizures likely to disrupt the work of co-workers? __Yes __No

24. Will your patient need more supervision at work than an unimpaired worker? __Yes __No

25. Can your patient work at heights? __Yes __No

26. Can your patient work with power machines that require an alert operator? __Yes __No

27. Can your patient operate a motor vehicle? __Yes __No

28. Can your patient take a bus alone? __Yes __No

29. Does your patient have any associated mental problems?

Check those that apply:

__ Depression
__ Irritability
__ Social isolation
__ Poor self-esteem

Short attention span
Memory problems
Behavior extremes
Other: _____

30. 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? _____

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

__ Incapable of even "low stress" jobs
__ Moderate stress is okay
__ Capable of low stress jobs
__ Capable of high stress work

Please explain the reasons for your conclusion: _____

_____

32. 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

33. Please describe any other limitations (such as limitations in the ability to sit, stand, walk, lift, bend, stoop, limitations in using arms, hands, fingers, 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:

_____

_____

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

_____ _____

Date *Signature*

Printed/Typed Name: _____

Address: _____

_____

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