STROKE 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. Frequency and length of contact: _____

   _____

2. Did your patient have a stroke? __ Yes __ No

   If yes, type of stroke: _____

3. Other diagnoses: _____

   _____

4. Prognosis: _____

5. Identify all of your patient's symptoms:

[ ] balance problems	[ ] vertigo/dizziness
[ ] poor coordination	[ ] headaches
[ ] loss of manual dexterity	[ ] difficulty remembering
[ ] weakness	[ ] confusion
[ ] slight paralysis	[ ] depression
[ ] unstable walking	[ ] emotional lability
[ ] falling spells	[ ] personality change
[ ] numbness, tingling or other	[ ] difficulty solving
[ ] sensory disturbance problems	
[ ] pain	[ ] problems with judgment
[ ] fatigue	[ ] double or blurred
[ ] vision/partial or complete blindness	
[ ] bladder problems	[ ] shaking tremor
[ ] nausea	[ ] speech/communication
[ ] other difficulties:	

_____

_____

6. Clinical findings: _____

_____

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

8. Does your patient have significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movement or gait and station? __ Yes __ No

9. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? __ Yes __ No

10. Are your patient's impairments (physical impairments plus any emotional impairments) *reasonable consistent* with the symptoms and functional limitations described in this evaluation? __ Yes __ No

11. How often is your patient's experience of pain, fatigue or other symptoms severe enough to interfere with attention and concentration?

[ ] Never [ ] Seldom [ ] Often [ ] Frequently [ ] Constantly

12. Have your patient's impairments lasted or can they be expected to last at least twelve months? __ Yes __ No

13. 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? _____

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. How long can your patient 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 a job which permits shifting positions *at will* from sitting, standing or walking?
__ Yes __ No

f. 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) On average, how long 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?

g. 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? _____%

h. 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.

i. 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.	[ ]	[ ]	[ ]	[ ]

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

	Never	**Rarely**	**Occasionally**	**Frequently**
Twist	[ ]	[ ]	[ ]	[ ]
Stoop (bend)	[ ]	[ ]	[ ]	[ ]
Crouch	[ ]	[ ]	[ ]	[ ]
Climb ladders	[ ]	[ ]	[ ]	[ ]
Climb stairs	[ ]	[ ]	[ ]	[ ]

k. Does your patient have *significant limitations* in 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:	___%	___%	___%

l. State the degree to which your patient should avoid the following:

ENVIRONMENTAL RESTRICTIONS:	NO RESTRICTION	AVOID CONCENTRATED EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID ALL EXPOSURE
Extreme cold				
Extreme heat				
High humidity				
Fumes, odors, dusts, gases				
Perfumes				
Cigarette smoke				
Soldering fluxes				
Solvents/ cleaners				
Chemicals				
List other irritants or allergens:				

m. 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: _____

_____

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

14. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, 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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