Traumatic Brain Injury
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: _____

_____

Does your patient exhibit: **Parkinson's disease**? □ Yes □ No
Traumatic brain injury? □ Yes □ No

3. Prognosis: _____

4. Please identify any signs/symptoms that your patient exhibits due to his/her impairments:

□ tremor □ rigidity □ bradykinesia □ postural instability
□ seborrhea □ chronic fatigue □ impaired gait □ saliva drooling
□ falls □ blepharoclonus □ reduced intellectual functioning
□ impaired attention & concentration □ impaired short term memory
□ impaired ability to arise from a seated position
□ soft/poorly modulated voice

5. If your patient exhibit tremors, characterize the nature and severity of the tremors and the parts of the body affected: _____

_____

_____

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:

□ Depression
□ Somatoform disorder
□ Psychological factors affecting physical condition
□ Anxiety
□ Personality disorder
□ 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?

□ 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: _____

15. If your patient was placed in a competitive job, identify those aspects of workplace stress that your patient would be unable to perform or be exposed to:

□ public contact □ routine, repetitive tasks at consistent pace
□ detailed or complicated tasks □ strict deadlines
□ fast paced tasks (e.g. production line)
□ close interactions with coworkers/supervisors
□ exposure to work hazards (e.g heights/moving machinery)

16. 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 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 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. What symptom(s) cause a need for breaks?

□ muscle weakness □ pain/paresthesia, numbness
□ chronic fatigue □ adverse effects of medication
□ other: _____

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 Twist Objects	**FINGERS: Fine Manipulations**	**ARMS: Reaching (incl. Overhead)**
Right:	**__%**	**__%**	**__ %**
Left:	**__%**	**__%**	**__ %**

n. If your patient has significant limitations with reaching, handling or fingering:

1. What symptom(s) cause limitations with use of the upper extremities?

□ tremors □ bradykinesia
□ side effects of medication □ sensory loss
□ rigidity □ other: _____

o. 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 three days per month
□ About one day per month □ About four days per month
□ About two 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 patient's ability to work at a regular job on a sustained basis:

_____

_____

_____

_____

_____ _____

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