

RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE

Name of Claimant: _____ SSN: _____

DEAR DOCTOR: PLEASE COMPLETE THE FOLLOWING ITEMS BASED ON YOUR CLINICAL EVALUATION OF THE CLAIMANT AND OTHER TESTING RESULTS. ANY ITEMS THAT YOU DO NOT BELIEVE YOU CAN ANSWER SHOULD BE MARKED N/A (NOT ANSWERABLE). NOTE: IN TERMS OF AN 8 HOUR WORKDAY: "OCCASIONALLY" EQUALS 0% TO 33% (1-2 HRS); "FREQUENTLY" 34% TO 66% (3-5 HRS); AND "CONTINUOUSLY" 67% TO 100% (6 TO 8 HRS).

I. In an 8-hr. workday, claimant can: (Circle full capacity for each activity)

A. Sit - No. hrs. - 0, 1, 2, 3, 4, 5, 6, 7, 8.

B. Stand - No. hrs. - 0, 1, 2, 3, 4, 5, 6, 7, 8.

C. Walk - No. hrs. - 0, 1, 2, 3, 4, 5, 6, 7, 8.

D. Work - No. hrs. - 0, 1, 2, 3, 4, 5, 6, 7, 8.

(Sitting, standing or walking)
Limitations due to

II. Claimant can lift:

	Never	Occasionally	Frequently	Continuously
A. Up to 10 lbs.	()	()	()	()
B. 11 - 20 lbs.	()	()	()	()
C. 21 - 50 lbs.	()	()	()	()
D. 51 - 100 lbs	()	()	()	()

Limitations due to:

III. Claimant can carry:

	Never	Occasionally	Frequently	Continuously
A. Up to 10 lbs.	()	()	()	()
B. 11 - 20 lbs.	()	()	()	()
C. 21 - 50 lbs.	()	()	()	()
D. 51 - 100 lbs	()	()	()	()

Limitations due to:

IV. Claimant can use hands for repetitive action such as:

Simple Grasping Pushing & Pulling Fine Manipulation

- A. Right () Yes () No () Yes () No () Yes () No
 B. Left () Yes () No () Yes () No () Yes () No

Limitations due to:

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V. Is there evidence of any disorder that would limit in any way repetitive hand action involving:

- | | | | | |
|-----------------|----------------|----------------|-------------------|----------------|
| Simple Grasping | Pushing & | Pulling | Fine Manipulation | |
| A. Right | () Yes () No | () Yes () No | () Yes () No | () Yes () No |
| B. Left | () Yes () No | () Yes () No | () Yes () No | () Yes () No |

Limitation due to

VI. Claimant can use feet for repetitive movements as in operating foot controls:

- | | | |
|----------------|----------------|----------------|
| Right | Left | Both |
| () Yes () No | () Yes () No | () Yes () No |

Limitation due to:

VII. Claimant is able to:

- | | Never | Occasionally | Frequently | Continuously |
|----------------|-------|--------------|------------|--------------|
| A. Bend | () | () | () | () |
| B. Squat | () | () | () | () |
| C. Crawl | () | () | () | () |
| D. Climb | () | () | () | () |
| E. Reach above | () | () | () | () |
| F. Stoop | () | () | () | () |
| G. Crouch | () | () | () | () |
| H. Kneel | () | () | () | () |

Limitations due to:

VIII. Claimant can tolerate:

- | | Not at all | Occasionally | Frequently | Continuously |
|---|------------|--------------|------------|--------------|
| A. Exposure to unprotected heights | () | () | () | () |
| B. Being around moving machinery | () | () | () | () |
| C. Exposure to marked temperature changes | () | () | () | () |
| D. Driving automotive equipment | () | () | () | () |
| E. Exposure to dust, fumes & gases | () | () | () | () |
| F. Exposure to noise | () | () | () | () |
| G. Other _____ | () | () | () | () |

Limitations due to:

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IX. Objective signs of pain:

Redness Joint deformity Spinal deformity X-ray

Muscle spasm Other (specify) _____

X. Pain is:

Mild (would constitute an awareness but causing no handicap in the performance of the particular activity, would be considered as non ratable permanent disability).

Slight (could be tolerated but would cause some handicap in the performance of the activity precipitating pain).

Moderate (could be tolerated but would cause marked handicap in the performance of the activity precipitating pain).

Severe (would preclude the activity precipitating the pain).

Remarks:

(Date)

(Signature of Physician)