

**MUSCULOSKELETAL IMPAIRMENT RESIDUAL
FUNCTIONAL CAPACITY QUESTIONNAIRE**

TO: _____
RE: _____, d.o.b. _____
Social Security Number: _____

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. Nature, frequency and length of contact: _____
_____.
2. Diagnoses: _____
3. Prognosis: _____
4. Identify the symptoms, including pain, dizziness, fatigue, etc.: _____

5. If your patient exhibits pain, characterize the nature, location, frequency, precipitating factors, and severity of your patient's pain: _____

6. Identify any positive objective signs of your patient's symptoms:

<input type="checkbox"/> Reduced range of motion	<input type="checkbox"/> Positive straight leg raising
<input type="checkbox"/> Joints affected: _____ _____	<input type="checkbox"/> Tenderness
	<input type="checkbox"/> Crepitus
<input type="checkbox"/> Sensory changes	<input type="checkbox"/> Trigger points
<input type="checkbox"/> Reflex changes	<input type="checkbox"/> Redness
<input type="checkbox"/> Impaired sleep	<input type="checkbox"/> Swelling
<input type="checkbox"/> Weight loss	<input type="checkbox"/> Muscle spasm
<input type="checkbox"/> Impaired appetite	<input type="checkbox"/> Muscle weakness
<input type="checkbox"/> Abnormal posture	<input type="checkbox"/> Muscle atrophy
<input type="checkbox"/> Abnormal gait	

Other clinical findings: _____

7. Is your patient a malingerer? Yes No
8. Identify any psychological conditions affecting the patient's pain:
 Depression Anxiety
 Somatoform disorder Psychological factors affecting physical Condition
 Personality disorder
 Other: _____

9. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? Yes No
10. Are your patient's physical impairments plus any emotional impairments reasonably consistent with the symptoms (including pain) and functional limitations described in this evaluation? Yes No
 If no, please explain: _____

11. How often is your patient's experience of pain sufficiently severe to interfere with attention and concentration?
 Never Seldom Often Frequently Constantly
12. To what degree is your patient limited in the ability to deal with the normal stresses of competitive employment such as working at a consistent pace, working appropriately with coworkers and supervisors, not taking an excessive number of breaks, etc.?
 No limitation Slight limitation Moderate limitation
 Marked limitation Extreme limitation
13. Identify the side effects of any medication which may have implications for working, e.g. dizziness, drowsiness, stomach upset, etc. _____

14. Have the patient's impairments lasted or can they be expected to last at least twelve months? Yes No
15. As a result of your patient's impairments, estimate your patient's functional limitations assuming the patient were placed in a **competitive work situation on an ongoing basis**:
- A. **Circle** the one number that best estimates how long the patient can **continuously** sit and stand **at one time**?
- | | | |
|-------------|---------------------------|------------------------|
| Sit: | <u>0</u> 5 10 15 20 30 45 | <u>1</u> 2 3 4 5 6 7 8 |
| | Minutes | Hours |

I. Does the patient have significant limitations in the ability to use hands and fingers *for actions in a competitive job* such as:

	Grasp, Twist	Turn Objects	Fine Manipulation	Reaching (Including Overhead)
<u>Right</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
<u>Left</u>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

If the answer to any question is "yes", please explain: _____

J. Does the patient have the ability to bend and twist at the waist?

Not at all Occasionally Frequently

K. On the average, how often do you anticipate that the patient's impairments or treatment would cause the patient to be absent from work?

Never or less than one a month About twice a month
 About once a month More than twice a month
 More than three times a month

16. Please describe any other limitations that would affect this patient's ability to work at a regular job on a sustained basis:

17. What is the **earliest date** that the above restrictions apply?

Date: _____

Signed: _____

Print/Type Name: _____

Address: _____
