FORM 3: Sample Questionnaire (General)

RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE

Re: _____ (Name of Patient)

Patient's Date of Birth: _____

Please answer the following questions concerning your patient's autoimmune disorder(s) and other medical impairments. *Please attach a copy of your most recent curriculum vitae (CV).*

1. Date of first visit: _____

   Frequency of visits: _____

2. Primary diagnosis: _____

   _____

3. Other diagnoses: _____

4. Prognosis: _____

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

6. Does your patient experience persistent **fatigue**? ___ Yes ___ No

   If yes, please describe your patient's history of fatigue:

   _____

   _____

   _____

   _____

7. Does your patient have **pain**? ___ Yes ___ No

   If yes:

   a. Please characterize the **severity** of your patient's pain:

   __ mild ___ moderate __ severe

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b. Identify the **location and frequency** of your patient's pain by marking or shading the relevant areas of the body and labeling C for constant, F for frequent, and I for intermittent:

c. Describe the nature of your patient's pain:

_____

_____

_____

d. Identify any factors that precipitate pain:

__ weather changes __ stress

__ fatigue __ hormonal changes

__ movement/overuse __ static position

__ cold __ other: _____

8. Does your patient have symptoms of mental or cognitive impairment? ___ Yes ___ No

If yes, please explain:

_____

_____

9. Please describe any other symptoms not mentioned above:

_____

_____

_____

10. Identify positive clinical findings and test results (laboratory tests, imaging, etc.) which show your patient's impairments:

_____

_____

_____

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

If yes, please explain:

_____

_____

12. List any medications prescribed and identify their **side effects** experienced by your patient:

Medication Side Effects

_____

_____

_____

_____

13. Describe other treatment and your patient's response:

_____

_____

_____

14. Is your patient a malingerer? ___ Yes ___ No

15. Does your patient overstate his/her symptoms? ___ Yes ___ No

16. Are your patient's impairments (physical and/or mental) *reasonably consistent* with the symptoms and functional limitations described in this evaluation? ___ Yes ___ No

If no, please explain: _____

_____

17. How often during a typical eight-hour workday would your patient experience fatigue, pain, or other symptoms severe enough to interfere with **attention and concentration** needed to perform even simple work tasks?

□ Never (1 – 10%) □ Rarely (11 – 33%) □ Occasionally (34 – 66%) □ Frequently (67-100%) □ Constantly

18. Would work stress aggravate your patient's condition? ___ Yes ___ No

Please explain: _____

_____

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

□ Cannot tolerate even low stress
□ Can tolerate low stress
□ Can tolerate moderate stress
□ Can tolerate high stress

20. Please estimate your patient's functional limitations due to his/her impairments if your patient were placed in a *competitive work situation*:

a. How long could your patient sit ***at one time,*** continuously, before needing to get up? Please circle the number of minutes or hours.

Sit: 0 5 10 15 20 30 45 (Minutes) 1 2 >2 (Hour(s))

b. How long could your patient stand ***at one time***, continuously, before needing to change position (sit, walk around, etc.)? Please circle the number of minutes or hours.

Stand: 0 5 10 15 20 30 45 (Minutes) 1 2 >2 (Hour(s))

c. How many city blocks could your patient walk ***at one time,*** continuously, before needing to rest or experiencing excessive pain? _____

d. How long could your patient sit and stand/walk in ***total*** during an *eight-hour workday* with normal breaks? Please circle the number of hours.

Sit: 0 – ½ <1 <2 2 4 6+ (Hour(s))

Stand/walk: 0 – ½ <1 <2 2 4 6+ (Hour(s))

e. Does your patient need a job which permits changing positions (sitting, standing, walking) ***at will***? ___ Yes ___ No

f. During prolonged sitting, should your patient's leg(s) be elevated? ___ Yes ___ No

If yes:
i. How *high* should the leg(s) be elevated? _____

ii. If your patient had a sedentary job, what *percentage of time* during an eight-hour workday should the leg(s) be elevated? _____

g. Does your patient need to use a cane or other assistive device when standing or walking?
___ Yes ___ No

h. Does your patient need to include periods of walking around during an eight-hour workday?
___ Yes ___ No

If yes:

i. Approximately how *frequently* must your patient walk around? Please circle the interval in minutes.

Every 1 5 10 15 20 30 45 60 90
Minute(s)

ii. Approximately how *long* must your patient walk each time? Please circle the number of minutes.

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15 >15
Minute(s)

i. Would your patient sometimes need to take unscheduled breaks during an eight-hour workday? ___ Yes ___ No

If yes:

i. How *frequently*, on average, would your patient need unscheduled breaks?

_____

ii. How *long*, on average, would your patient need to rest before returning to work?

_____

iii. During these breaks, would your patient need to
□ sit quietly? □ lie down?

j. For what percentage of time can your patient lift and carry the following amounts of weight during an eight-hour workday in a competitive work situation?

	Never 0%	Rarely 1-10%	Occasionally 11-33%	Frequently 34-66%
Less than 10 lbs.	( )	( )	( )	( )
10 lbs.	( )	( )	( )	( )
20 lbs.	( )	( )	( )	( )
50 lbs.	( )	( )	( )	( )

k. For what percentage of time can your patient perform the following activities during an eight-hour workday in a competitive work situation?

	Never 0%	Rarely 1-10%	Occasionally 11-33%	Frequently 34-66%
Twist	( )	( )	( )	( )
Stoop (bend)	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Climb stairs	( )	( )	( )	( )
Climb ladders	( )	( )	( )	( )

l. For what percentage of time can your patient perform the following activities during an eight-hour workday in a competitive work situation?

	Never 0%	Rarely 1-10%	Occasionally 11-33%	Frequently 34-66%
Look down	( )	( )	( )	( )
Turn head	( )	( )	( )	( )
Look up	( )	( )	( )	( )
Hold head static position	( )	( )	( )	( )

m. Would your patient have *significant limitations* in doing *repetitive* fingering, handling, or reaching? ___ Yes ___ No

i. If yes, for what percentage of time can your patient use fingers/hands/arms for the following repetitive activities during an eight-hour workday in a competitive work situation?

	FINGERS: **Fine Manipulations**	**HANDS:** **grasping, turning, twisting objects**	**ARMS:** **reaching (including overhead)**
Right:	%	%	%
Left:	%	%	%

n. State the degree to which your patient should avoid the following environmental conditions:

	AVOID ALL EXPOSURE	AVOID EVEN MODERATE EXPOSURE	AVOID CONCENTRATED EXPOSURE	NO RESTRICTION
Extreme cold				
Extreme heat				
Wetness				
Humidity				
Noise				
Fumes, odors, dusts, gases, poor ventilation, etc.				
Hazards (machinery, heights, etc.)				

o. Are your patient's impairments likely to produce "bad days" and "better days"?
___ Yes ___ No

p. On average, how many days per month would your patient likely be absent from work as a result of impairments or treatment:

___ Never
___ About 1 day/month
___ About 2 days/month
___ About 3 days/month
___ About 4 days/month
___ More than 4 days/month

21. Is your patient totally disabled from his/her own occupation? (See attached description)
___ Yes ___ No

If yes, please explain what makes your patient unable to work in his/her own occupation:

_____

_____

_____

22. Is your patient totally disabled from *any* occupation? ___ Yes ___ No

If yes, please explain what makes your patient unable to work in any occupation:

_____

_____

_____

_____ _____

Date Signature

Name: _____

Specialty: _____

Address: _____

_____

_____

*This form has been adapted from a form published by Thomas E. Bush, "Social Security Disability Practice, 2nd Edition, James Publishing, 2004.