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)