# FUNCTIONAL CAPACITY EVALUATION

To: _____

Re: _____ (Name of Patient)

_____ (Patient's Social Security No.)

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.

## I. Type of Treatment and Diagnosis

1. Nature, frequency, and length of contact: _____

_____

_____

2. Diagnosis: _____

_____

_____

## II. Objective Findings

3. Identify the clinical findings, laboratory and test results which show the patient's medical impairments:

_____

_____

_____

_____

4. Identify your patient's symptoms, including pain, dizziness, fatigue, etc.:

_____

_____

_____

_____

## III. Evaluation of pain

If your patient exhibits pain:

5. Describe the nature, location, radiation, frequency, precipitating factors, and severity of your patient's pain:

_____

_____

_____

_____

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

| | | | |
|---|---|---|---|
| [] | Significantly reduced ROM | [] | Tenderness |
| [] | SLR left at _____ | [] | Crepitus |
| | right at _____ | [] | Swelling |
| [] | X-ray | [] | Redness |
| [] | Joint Deformity | [] | Reflex changes |
| [] | Spinal Deformity | [] | Muscle spasm |
| [] | Sensory loss | [] | Muscle atrophy |
| [] | Weight loss | [] | Muscle weakness |
| [] | Impaired sleep | [] | Impaired appetite or gastritis |

7. Other signs and explanations: _____

_____

_____

8. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? [ ] Y [ ] N

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

_____

_____

9. 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 the pain.)

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

_____ Severe (would preclude the activity precipitating the pain.)

10. How often is your patient's experience of pain or other symptoms severe enough to interefere with attention and concentration

Never Seldom Often Frequently Constantly

11. Can your patient's combined physical and emotional impairments be reasonably expected to produce the symptoms (including pain) and functional limitations described in this evaluation? [] Y [] N

A. Please explain: _____

_____

12. Identify medications taken by your patient and side effects thereto which may have implications for working, e.g., dizziness, drowsiness, stomach upset, etc.:

_____

_____

13. Have the patient's impairments lasted or can they be expected to last at least twelve months? [] Y [] N

14. Prognosis: _____

_____

## IV. Specific Functional Impairments and Limitations of Patient If Placed in a Competitive Work Environment

15. How long would you estimate that your patient could continuously sit, stand, and walk at one time?

A. Sit

0 5 10 15 20 30 45 1 2 3 4 5 6 7 8
Minutes Hours

B. Stand

0 5 10 15 20 30 45 1 2 3 4 5 6 7 8
Minutes Hours

C. Walk

0 5 10 15 20 30 45 1 2 3 4 5 6 7 8
Minutes Hours

16. Does this patient need to include periods of walking during an 8-hour work day?
[ ] Y [ ] N

A. If yes, how often should this patient walk?

1 5 10 15 20 30 45 60 90
Minutes

B. How long must this patient walk each time?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Minutes

17. Does this patient need a job which permits shifting positions at will from sitting, standing, or walking? [] Y [] N

18. How long do you estimate that your patient could sit, stand and walk total in an eight-hour work day (with normal breaks)?

| Sit: | Stand: | Walk: | |
|---|---|---|---|
| [] | [] | [] | Less than 2 hours |
| [] | [] | [] | About 2 hours |
| [] | [] | [] | About 4 hours |
| [] | [] | [] | At least 6 hour |

19. Do you think that this patient could get through an 8-hour working day (with normal breaks) on a sustained basis, without lying down during the working day?
[ ] Y [ ] N

20. While sitting, should this patient's legs be elevated? []Y [] N

21. While engaging in occasional standing/walking, should the patient use a cane or other assistive device? [] Y [] N

22. How many pounds do you estimate that this patient could lift and carry in a competitive work situation?

| | Never | Occasionally | Frequently | Continuously: |
|---|---|---|---|---|
| 10 lbs. or less | [] | [] | [] | [] |
| 11-20 lbs. | [] | [] | [] | [] |
| 21-50 lbs. | [] | [] | [] | [] |
| 51-100 lbs. | [] | [] | [] | [] |

*In an average 8-hour work day, "occasionally" means less than 1/3 of the work day; "frequently" means between 1/3 to 2/3 of the work day, and "continuously" means all the time.*

23. Does the patient have significant limitations in the ability to use hands and fingers for actions, such as:

| | Grasping, Turning Twisting Objects | | Fine Manipulations | | Reaching (up & down) | | Pushing & Pulling | |
|---|---|---|---|---|---|---|---|---|
| Right | []Y | []N | []Y | []N | []Y | []N | []Y | []N |
| Left | []Y | []N | []Y | []N | []Y | []N | []Y | []N |

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

_____

_____

24. Does the patient have significant limitations in the ability to use feet and toes for repetitive movements as in operating foot controls:

Right []Y []N

Left []Y []N

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

_____

25. Does the patient have the ability to:

| | | Not at all | Occasionally | Frequently |
|---|---|---|---|---|
| a. | Bend | _____ | _____ | _____ |
| b. | Squat | _____ | _____ | _____ |
| c. | Crawl | _____ | _____ | _____ |
| d. | Climb | _____ | _____ | _____ |
| e. | Reach | _____ | _____ | _____ |
| f. | Stoop | _____ | _____ | _____ |
| g. | Crouch | _____ | _____ | _____ |
| h. | Kneel | _____ | _____ | _____ |

Limitations due to:_____

_____

26. Claimant can tolerate:

| | Not at All | Occasionally | Frequently |
|---|---|---|---|
| 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 [] [] []

Limitations due to:_____

_____

27. 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
[] Less than once a month
[] About once a month
[] About twice a month
[] Three or more times a month

28. Please describe any other limitations not yet discussed that would affect this patient's ability to work at a regular job on a sustained basis:

_____

_____

_____

_____

29. Within reasonable medical certainty, what is the earliest date that the limitations described in this questionnaire applied to your patient:_____

Date: _____ Signed: _____

Print/Type Name: _____

Address: _____

_____

_____

Please return this form to: