RESIDUAL FUNCTIONAL CAPACITY PHYSICAL ASSESSMENT

Patient Name	Social Security Number

If additional room is needed to answer a question, please **use a separate sheet** of paper and reference which question you are addressing in your extended remarks.

PART I: TREATMENT PERIOD AND DIAGNOSIS

1. When did you first see the patient?

2. How often do you see the patient and when did you last see the patient?

3. What diagnoses are producing the limitations assessed below?

PART II: ASSESSMENT OF RESIDUAL FUNCTIONAL CAPACITY

In responding on the next page, use

- **Rare to occasional** to mean **up to one-third of a total eight-hour workday**, cumulatively, not necessarily continuously.
- **Frequent** to indicate **one-third to two-thirds of an eight-hour workday,** cumulatively, not necessarily continuously.

Exertion and Movement	Never	Rare to Occasional	Frequent	No Limitation	Duration of limitation to date
Lift and/or carry in an eight - hour work day					
less than 10 lbs.					
20 lbs.					
50 lbs.					
100 lbs. or more					
Push/pull including hand or foot controls in an 8-hour day					
Stand and/or walk with usual breaks in 8-hour day					
Hand-held assistive device needed to ambulate. (If needed, describe device on last page.)					
Sit (with usual breaks) in an eight-hour workday					
Must periodically relieve pain or discomfort by alternating sitting and standing. (Explain frequency and duration of position changes on last page.)					
Climb ramp or stairs					
Climb ladder					
Balance					
Stoop					
Kneel					
Crouch					
Crawl					
Reach above shoulders					
Reach shoulders to waist					
Reach waist to floor					
Handle objects (grip/gross manipulation)					
Fine motor control/manipulation with fingers					

Environmental Exposure	Avoid All	Avoid Concentrated	Avoid Moderate	No Limitation	Duration of limitation to date
Extreme cold					
Extreme heat					
Dampness or wetness					
Humidity					
Fumes, gases, poor ventilation					
Dust					
Machinery					
Heights					

Communication and Senses	Limited	Unlimited	Duration of limitation to date
Hearing			
Speaking			
Feeling (skin receptors)			
Near visual acuity (best correction)			
Far visual acuity (best correction)			
Depth perception			
Accommodation			
Color vision			
Field of vision (peripheral vision)			

1. Does pain play a factor in any limitations listed above? If so, what is the diagnostic source of the pain?

2. What is the level, frequency, and location of the pain?

3. Are the patient's pain reports credible? Please explain the basis of your reply.

4. Does fatigue play a factor in any limitations listed above? If so, what is the diagnostic source of the fatigue?

5. Are the patient's reports of fatigue levels credible? Please explain the basis of your reply.

6. How many days per month, if any, would the patient need to miss work either due to symptomology or to attend treatment appointments?

7. What, if any, accommodations in the workplace would you expect the patient to need?

8. Are there any other factors that relate to your patient's ability to work consistently throughout a work week or to perform activities of daily living? (If you indicated above that the patient must use assistive devices to walk or must change positions throughout workday, explain here.)

PART III: TREATMENT HISTORY

1. What treatment has been initiated so far? What have the results/effectiveness of the treatment been?

2. What medical testing or diagnostic procedures has the patient undergone? What, when, and where?

3. Has the patient experienced any side effects from treatment? If so, please identify and describe the severity of each.

4. Is the patient being seen by other medical providers? If so, please give the provider's name, specialty, reason for care, and if available contact information.

5. Is the patient's condition expected to improve? Deteriorate? Remain unchanged? Please explain the basis of your opinion. If change is expected, please indicate how soon and to what degree/in what manner?

Signature	**Date**
Print Name	
Clinic, Facility, or Office	
Address	
Phone	**Email**