Residual Functional Capacity Questionnaire
AUTO IMMUNE DISORDER

Patient: _____

DOB: _____

Physician completing this form: _____

Please complete the following questions regarding this patient's impairments and attach all supporting treatment notes, radiologist reports, laboratory and test results.

Symptoms & Diagnosis

Does this patient have an auto immune disorder? ☐Yes ☐No
If yes, what type? _____

What diagnoses has this patient received? _____

_____

Describe the patient's symptoms, such as pain, dizziness, fatigue, etc. _____

_____

_____

Does the patient have chronic pain/paresthesia? ☐ Yes ☐ No

Describe the patient's type of pain, location, frequency, precipitating factors, and severity. _____

_____

_____

Please indicate all positive objective signs exhibited by the patient:

☐ Anxiety	☐ Aspergillus	☐ Abdominal cramping/pain	☐ Bladder infections
☐ Bronchitis (recurrent)	☐ Candida	☐ Chronic diarrhea	☐ Chronic fatigue
☐ Depression	☐ Disturbed sleep	☐ Endo carditis	☐ Headaches
☐ Hemolytic anemia	☐ Herpes complex	☐ Impaired appetite	☐ Low grade fever
☐ Lymph nodes enlarged		☐ Lypophopenia	☐ Malaise (severe)
☐ Nausea/vomiting	☐ Neuropathy	☐ Night sweats	☐ Oral ulcers
☐ Peritonitis	☐ Renal involvement	☐ Raynaud's phenomenon	☐ Septic arthritis
☐ Sinusitis (chronic)	☐ Sore throat (recurrent)	☐ Urinary urgency or incontinence	
☐ Vertigo	☐ Visual disturbances	☐ Weight loss	☐ Yeast infections

☐ Other: _____

What is the earliest date that the above description of limitations applies? _____

Have these symptoms lasted (or are they expected to last) twelve months or longer? ☐ Yes ☐ No

Are this patient's symptoms and functional limitations impacted by emotional factors? ☐ Yes ☐ No
If yes, please mark any known psychological conditions that affect this patient's pain:
☐ Depression ☐ Anxiety ☐ Somatoform disorder ☐ Personality disorder
☐ Other: _____

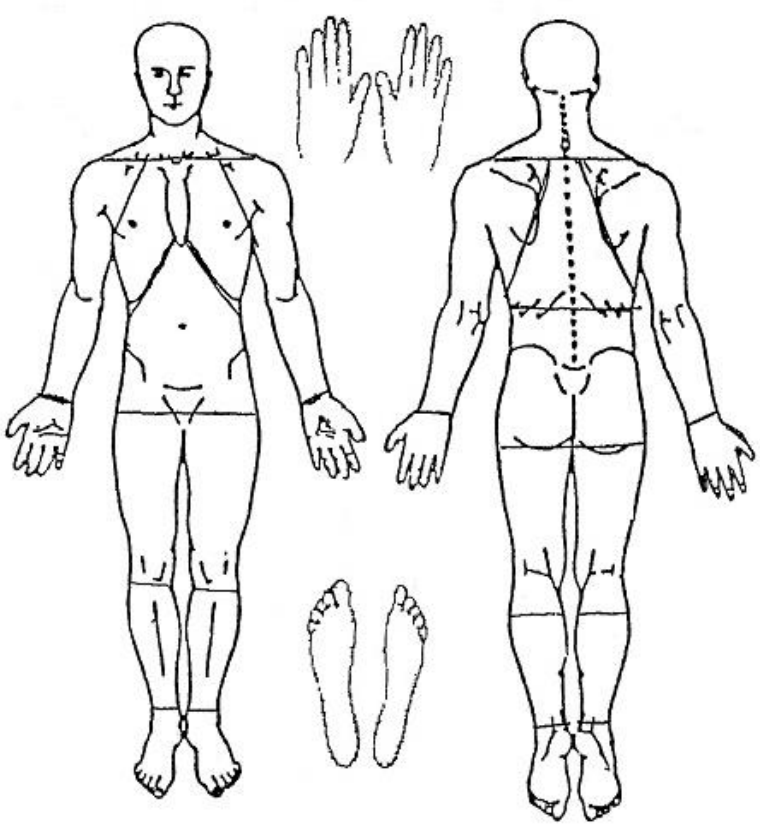
Are these physical and emotional impairments reasonably consistent with the patient's symptoms and functional limitations? ☐ Yes ☐ No

If no, please explain: _____

_____

Testing & Treatments

Identify the location and frequency of the patient's pain/paresthesia by shading the relevant body areas and labeling each as Constant (C), Frequent (F), or Occasional (O)



Identify any positive clinical findings and test results, such as granulocytopenia, T and B cell deficiency, hypogammaglobulinemia, positive ANA, etc.: _____

_____

_____

Please list the patient's current medications: _____

_____

Please indicate the treatment type, start dates, and frequency: _____

_____

What is the patient's prognosis? _____

Is this patient a malingerer? ☐ Yes ☐ No

Functional Work Limitations

When answering the following questions, please consider this patient's impairments and estimate his or her ability to work in a competitive work environment for an 8-hour shift with normal breaks.

How often do you expect this patient's pain or symptoms to interfere with the attention and concentration necessary to perform simple work tasks?

- ☐ Never
- ☐ Rarely (1% to 5% of an 8 hour working day)
- ☐ Occasionally (6% to 33% of an 8 hour working day)
- ☐ Frequently (34% to 66% of an 8 hour working day)
- ☐ Constantly

Mark the aspects of workplace stress that the patient would likely be unable to perform.

- ☐ Detailed or complicated tasks
- ☐ Strict deadlines
- ☐ Close interaction with coworkers/supervisors
- ☐ Routine, repetitive tasks at consistent pace
- ☐ Fast-paced tasks, such as assembly lines
- ☐ Other:_____

_____

Is this patient taking any medications with side effects that may affect his or her ability to work?

☐ Yes ☐ No

If yes, please list possible side effects. _____

_____

How far can this patient walk without rest or severe pain?_____

How long can this patient sit comfortably at one time before needing to get up?

Minutes: 0 5 10 15 20 30 45

Hours: 1 2 Longer than 2

What must the patient usually do after sitting this long?

☐ Stand ☐ Walk ☐ Lie Down ☐ Other: _____

How long can this patient stand comfortably at one time before needing to sit or walk around?

Minutes: 0 5 10 15 20 30 45

Hours: 1 2 Longer than 2

What must the patient usually do after sitting this long?

☐ Sit ☐ Walk ☐ Lie Down ☐ Other: _____

How long can this patient sit in an 8-hour working day?

- ☐ less than 2 hours
- ☐ about 2 hours
- ☐ about 4 hours
- ☐ at least 6 hours

How long can this patient stand and/or walk in an 8-hour working day?

- ☐ less than 2 hours
- ☐ about 2 hours
- ☐ about 4 hours
- ☐ at least 6 hours

Does the patient require a job with ready access to a bathroom? ☐Yes ☐No

Might the patient's symptoms likely cause unscheduled bathroom breaks? ☐ Yes ☐ No
If yes, how often? 1 2 3 4 5 6 7 8 9 10 >10 times

Might the patient require additional unscheduled breaks to lie down, change soiled clothing, or rest at unpredictable times? ☐ Yes ☐ No
If yes, how many times? 1 2 3 4 5 6 7 8 9 10 >10
For how many minutes? <5 5 10 20 30 45 60 90 >90
For which symptoms?
☐ Chronic fatigue ☐ Medication side effects ☐ Nausea/vomiting
☐ Pain/paresthesia ☐ Urinary frequency/incontinence ☐ Weakness
☐ other: _____

With prolonged sitting, should the patient's leg(s) be elevated?
☐ Yes ☐ No
If yes, how high? _____ For what percentage of time in an 8-hour day? _____%

What symptom(s) cause a need to elevate the legs?
☐ Claudication ☐ Edema ☐ Pain/paresthesia
☐ other: _____

During occasional standing/walking, does this patient require a cane or other assistive device?
☐ Yes ☐ No

How many pounds can this patient lift and carry?

	Never	Rarely	Occasionally	Frequently
Less than 10 lbs.	☐	☐	☐	☐
10 lbs.	☐	☐	☐	☐
20 lbs.	☐	☐	☐	☐
50 lbs.	☐	☐	☐	☐

How often can the patient perform the following activities?

	Never	Rarely	Occasionally	Frequently
Twist	☐	☐	☐	☐
Stoop (bend)	☐	☐	☐	☐

Does this patient have significant limitations with repetitive reaching, handling or fingering?
☐ Yes ☐ No
If yes, please indicate the percentage of time this patient can perform the following activities:
Using hands to grasp, turn and twist objects Right _____% Left _____%
Using fingers for fine manipulation Right _____% Left _____%
Using arms to reach out and overhead Right _____% Left _____%

Do the patient's impairments require limited exposure to changes in the environment?

	No Exposure Restriction	Avoid Prolonged Exposure	Avoid Moderate Exposure	Avoid All Exposure
Extreme Cold	☐	☐	☐	☐
Extreme Heat	☐	☐	☐	☐
Humidity	☐	☐	☐	☐
Sunlight	☐	☐	☐	☐
Ultraviolet Light	☐	☐	☐	☐
Others: _____	☐	☐	☐	☐
_____	☐	☐	☐	☐
_____	☐	☐	☐	☐

Are this patient's impairments likely to produce "good days" and "bad days"?

☐ Yes ☐ No

If yes, please estimate, on average, how many days per month your patient is likely to be absent from work as a result of the impairments or treatment:

☐ Never
☐ About one day per month
☐ About two days per month
☐ About three days per month
☐ About four days per month
☐ More than four days per month

Please describe any other limitations that might affect this patient's ability to work at a regular job on a sustained basis, such as psychological issues, limited vision or hearing, or the inability to adjust to temperature, wetness, humidity, noise, dust, fumes, gases or hazards, etc.

_____

_____

_____

Please describe additional tests or clinical findings not described on this form that clarify the severity of the patient's impairments.

_____

_____

_____

Completed by:

_____
Physican's Printed Name

_____
Physician's Signature

_____
Address

_____

_____

_____
Date