Residual Functional Capacity Form/Medical Opinion Statement

Patient Name: _____ Date of Birth: _____
Social Security #:_____

Please respond to the following questions regarding your patient's ability to perform work-related physical activities. When answering the questions, please be specific with regards to what evidence in your patient's records supports your opinion. This will be used as medical evidence for a Social Security disability claim or a private long-term disability claim.

Section A: Medical History

1. When did you begin treating the patient? _____

2. How often do you see the patient? _____

3. What is your diagnosis of the patient's medical impairment(s)? _____

_____

4. What is your prognosis for the patient (good, fair, poor)? _____

5. Please list the objective medical findings that you use to support your diagnosis:

_____

6. Please describe any treatment the patient has completed so far and the results of the

treatment: _____

Section B: Signs and Symptoms

7. Please identify the medical signs, present on physical examination, of your patient's

impairment(s): _____

_____

8. Please identify the symptoms of your patient's impairment(s): _____

_____

Section C: Functional Limitations

9. Does your patient have limitations in their ability to stand? _____ Yes _____No

If yes, please circle the number that best describes the total amount your patient can stand in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can stand at one time before they need to sit down (in minutes or hours)?

_____

10. Does your patient have limitations in their ability to walk? _____ Yes _____No

If yes, please circle the number that best describes the total amount your patient can walk in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can walk at one time before they need to sit down (in minutes, hours, or distance)?

_____

Does your patient require an ambulatory aid, such as a walker or cane?

_____ Yes _____No

12. Does your patient have limitations in their ability to sit? _____ Yes _____No

If yes, please circle the number that best describes the total amount your patient can sit in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can sit at one time before they need to get up (in minutes or hours)?

_____

13. Does your patient have limitations on lifting and carrying? _____ Yes _____No

If yes, please circle the number that best describes the heaviest amount, in pounds, that your patient can lift or carry *occasionally* (up to 1/3 of the workday):

Less than 10# 10# 20# 50# 100#

Please circle the number that best describes the heaviest amount, in pounds, that your patient can lift or carry *frequently* (up to 2/3 of the workday):

Less than 10# 10# 20# 50# 100#

14. Does your patient need to be able to change positions at will? _____ Yes _____No

If yes, how often do you think your patient will need to shift positions during the workday? _____

15. Does your patient need to be able to lie down during the day? _____ Yes _____No

If yes, how often do you think your patient will need to lie down during the day and for how long? _____

16. Does your patient need to be able to elevate their legs? _____ Yes _____No

If yes, how long does your patient need to elevate their legs for and at what height (e.g., at waist level)? _____

17. Please check the box that best describes how often your patient can perform the following actions in an 8-hour workday:

	Rarely or Never (very little, if at all)	Occasionally (up to 1/3 of the day)	Frequently (1/3-2/3 of the day)
Twist	___	___	___
Bend	___	___	___
Crouch	___	___	___
Climb stairs	___	___	___
Climb ladders	___	___	___
Kneel	___	___	___
Crawl	___	___	___
Balance	___	___	___

18. Does your patient have limitations in the upper extremities? _____ Yes _____No

If yes, please check the box that best describes how often your patient can use their arms, hands, and fingers to perform the following activities:

	Rarely or Never (very little, if at all)	Occasionally (up to 1/3 of the day)	Frequently (1/3-2/3 of the day)
Reaching overhead	___	___	___
Reaching laterally	___	___	___
Handling	___	___	___
Fingering	___	___	___
Feeling	___	___	___
Grasping	___	___	___

19. Are your patient's symptoms exacerbated by exposure to certain environmental conditions? _____ Yes _____No

If yes, please check the box that best describes how often your patient should come into contact with the following factors:

	Avoid All Exposure	Avoid Concentrated Exposure	Avoid Moderate Exposure	No Restrictions
Extreme cold	___	___	___	___
Extreme heat	___	___	___	___
Wetness	___	___	___	___
Humidity	___	___	___	___
Noise	___	___	___	___
Fumes or gases	___	___	___	___
Hazards	___	___	___	___
Heights	___	___	___	___

20. Does your patient experience pain? _____ Yes _____No

If yes, please describe the location, intensity, and frequency of the pain:

_____

21. Do your patient's symptoms affect the ability to concentrate or maintain attention? _____ Yes _____No

    If yes, please circle the percentage that best reflects how much of the workday these symptoms would be severe enough to interfere with tasks:

    5% 10% 15% 20% 25% Over 25%

22. Do your patient's symptoms result in "good days" and "bad days"? _____ Yes _____No

23. Would your patient's symptoms or treatment result in absences from work? _____ Yes _____No

    If yes, please circle the amount that best represents how often your patient would miss work per month:

    Less than one day One day Two days Three days More than three days

Section D: Professional Observations

24. Has your patient cooperated with your treatment recommendations? _____ Yes _____No

    If not, please explain why your patient was unable to follow the recommended treatment: _____

25. Does your patient have a history of drug or alcohol abuse? _____ Yes _____No

    If yes, would your patient's symptoms exist or persist despite drug or alcohol use? _____ Yes _____No

26. Does your patient exaggerate symptoms? _____ Yes _____No

27. Do you expect the patient's limitations to last at least one year? _____ Yes _____No

28. On what date did these limitations begin? _____

29. In your opinion, are your patient's limitations reasonably consistent with the objective medical evidence and physical evaluations as a whole? _____ Yes _____No

Doctor's Name and Signature: _____Date: _____
Doctor's Address: _____