Residual Functional Capacity Form/Medical Opinion Statement

Patient Name: *Janet Weiss* **Date of Birth:** *01/01/1970*
Social Security #: *999-00-1111*

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?

    Ms. Weiss' initial intake visit was on September 9, 2019.

2. How often do you see the patient?

    I've seen her in person and remotely through telehealth videoconferencing every two months since then.

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

    Degenerative disc disease of the lumbar spine.

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

    Poor.

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

    Ms. Weiss underwent an X-ray on October 12, 2019 showing severe disc degeneration in the lumbar spine at L4-L5 and L5-S1. An MRI conducted on May 27, 2020 showed impingement of the anterior thecal sac. Another MRI dated February 20, 2022 revealed further degeneration at L3-L4, and a CT scan dated November 1, 2023 showed advanced degeneration at L4-L5.

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

    Ms. Weiss has undergone a series of corticosteroid injections in the lumbar spine, which were effective in reducing her pain for several weeks until the pain returned. We placed

a TENS nerve stimulation unit on April 30, 2022, which improved her ability to stand without pain somewhat but had no effect on her pain when walking. A lumbar laminectomy was conducted on January 5, 2023 with limited relief. Ms. Weiss has been scheduled for a revision surgery for early to mid 2024, since we did not obtain the expected results from the laminectomy. If this upcoming laminectomy is not effective, I would not recommend further surgical intervention.

Section B: Signs and Symptoms

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

Ms. Weiss experiences a reduced range of motion and tenderness to palpation in her lumbar spine.

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

She has numbness, tingling, and pain in her lower extremities. She has fatigue with repetitive motion in her legs and feet.

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)?

Ms. Weiss can stand for 15 minutes at one time.

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)?

Ms. Weiss can walk to the end of her driveway and back (about 5-10 minutes) without pain, but anything further requires that she sit down for 30 minutes before she can begin walking again.

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)?

Ms. Weiss cannot sit upright for longer than 30 minutes at a time. After 30 minutes, she needs to shift positions to relieve pain—ideally in a reclining position.

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 *occasionally* (up to 1/3 of the workday) lift or carry:

Less than 10# (10#) 20# 50# 100#

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

(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?

Every 15-30 minutes, depending on the day and whether she is seated, standing or walking.

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?

Lying down or reclining every two hours relieves pressure on the lumbar nerve that is being encroached on by her L5 vertebra.

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)?

At or above waist level, at least four times per day, for about two hours total.

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	_____	_X_	___
Bend	__X_	___	___
Crouch	__X__	___	___
Climb stairs	____	_X_	___
Climb ladders	__X__	___	___
Kneel	__X__	___	___
Crawl	__X__	___	___
Balance	__X__	___	___

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	___	_X__	___

Reaching laterally	___	___	__X__
Handling	___	___	__X_
Fingering	___	___	__X__
Feeling	___	___	__X__
Grasping	___	___	__X __

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	___	_X_	___	___
Extreme heat	___	_X_	___	___
Wetness	___	___	___	_X_
Humidity	___	___	___	_X_
Noise	___	___	___	_X_
Fumes or gases	___	___	___	_X_
Hazards	_X_	___	___	___
Heights	_X_	___	___	___

Ms. Weiss takes medications that have a slight sedative effect, so she should avoid heavy machinery, heights, or other hazards.

20. Does your patient experience pain? __ ✓ ___ Yes _____No

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

Dull and throbbing in the lower back, sometimes shooting down the legs and into the feet

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

If yes, please circle the percentage of the workday that best represents how often these symptoms are 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

Ms. Weiss reports that on "good days" her pain is at a 5 or a 6, but on "bad days" when the shooting pain occurs it is about an 8 or 9 out of 10.

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?

September 9, 2019, the date of initial intake

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: *Luis Mulberry, M.D.* **Date:** *2/21/2024*

Luis Mulberry, M.D.

Doctor's Address: *121 Cypress Ave, Townsville, TX, 81112*