# Arthritis Residual Functional Capacity Questionnaire

Name: _____Social Security Number:_____

Please answer the following questions concerning your **BEST ESTIMATE** of your patient's impairments. Attach all relevant treatment notes, radiologist reports, and laboratory and test results.

1. List any other diagnosed impairments?_____

2. Prognosis: _____

3. Have your patient's impairments lasted or can they be expected to last at least twelve months?
☐ Yes ☐ No

4. Identify you patient's symptoms:

| | | |
|---|---|---|
| ☐Muscle spasm | ☐Muscle Atrophy | ☐Difficulty sleeping |
| ☐Extremity Pain | ☐Difficulty walking | ☐Diminished reflexes |
| ☐Swelling | ☐Joint warmth | ☐Muscle weakness |
| ☐Joint deformity | ☐Joint instability | ☐Impaired appetite |
| ☐Reduced grip strength | ☐Depression | ☐Crepitus |
| ☐Sensory changes | ☐Redness | |
| ☐Difficulty thinking and concentrating | ☐Other_____ | |

5. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? ☐Yes ☐No

6. Are your patient's impairments reasonably consistent with the symptoms and functional limitations described? ☐Yes ☐No If No, explain:
_____

7. How often is pain severe enough to interfere with attention and concentration?
☐Never ☐Seldom ☐Often ☐Frequently
☐Constantly

8. To what degree is the patient limited in the ability to deal with work stress?
☐No limitation ☐Slight ☐Moderate ☐Marked ☐Severe limitation

9. Are your patient's impairments likely to produce "good days" and "bad days"? ☐Yes ☐No

10. Is your patient a malingerer? ☐Yes ☐No

11. As a result of your patient's impairments, estimate your patient's functional limitations if they were placed in a competitive work situation:

a. Circle hours and/or minutes that he/she can continuously sit and stand at one time:

| | **Minutes** | **Hours** |
|---|---|---|
| 1. Sit: | 0 5 10 15 20 30 45 | 1 2 more than 2 |
| 2. Stand: | 0 5 10 15 20 30 45 | 1 2 more than 2 |

b. Indicate how long he/she can sit and stand/walk total in an 8 hour work day:

| Sit | Stand/walk | |
|---|---|---|
| ☐ | ☐ | less than 2 hours |
| ☐ | ☐ | about 2 hours |
| ☐ | ☐ | about 4 hours |
| ☐ | ☐ | at least 6 hours |

12. Will your patient sometimes need to take unscheduled breaks during an 8 hour work day?
☐Yes ☐No

If yes, a) how often do you think this will happen? _____ and

b) How long will your patient need to rest before returning to work? _____

13. With prolonged sitting, should patient's leg(s) be elevated? ☐Yes ☐No

14. While engaging in occasional standing/walking, must your patient use a cane or other assistive device? ☐Yes ☐No

15. How many pounds can he/she lift and carry in a work situation?

| | Never | Occasionally | Frequently |
|---|---|---|---|
| Less than 10 lbs. | ☐ | ☐ | ☐ |
| 10 lbs. | ☐ | ☐ | ☐ |
| 20 lbs. | ☐ | ☐ | ☐ |
| 50 lbs. | ☐ | ☐ | ☐ |

16. Does your patient have significant limitations in doing repetitive reaching, handling or fingering? ☐Yes ☐No

Date: _____ Signature: _____

Printed/Typed Name: _____