Chronic Fatigue Syndrome
Residual Functional Capacity Questionnaire

Patient: _____ SSN: _____

Please answer the following questions concerning your patient's impairments. Attach all relevant treatment notes, radiologist reports, laboratory and test results which have not been provided to the Social Security Administration.

1. **Diagnosis: _____**
   _____
2. **Prognosis:_____**
   _____
3. **Identify all of your patient's symptoms:**

□ Fatigue	□ Difficulty thinking & concentrating
□ General malaise	□ Depression
□ Extremity pain & numbness	□ Excessive thirst
□ Difficulty walking	□ Abdominal pain
□ Muscle weakness	□ Rapid heart beat & chest pain
□ Loss of manual dexterity	□ Vascular disease & leg cramping
□ Episodic vision blurriness	□ Dizziness & loss of balance
□ Retinopathy	□ Swelling
□ Diarrhea	□ Headaches
□ Bladder infections	□ Chronic skin infections
□ Kidney problems	□ Insulin shock & coma
□ Frequency of urination	□ Hyper or hypoglycemic attacks
□ Bed wetting	□ Nausea & vomiting
□ Sweating	□ Infections & fevers

□ Other _____
_____
_____

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

5. **Are your patient's impairments (physical and emotional) reasonably consistent with the symptoms and functional limitations described in this evaluation?**
   □Yes □No
   If no, please explain: _____
   _____

6. **How often are your patient's symptoms severe enough to interfere with attention and concentration?**
   □Never □Seldom □Often □Frequently □Constantly

7. **To what degree is your patient limited in the ability to deal with work stress?**
   □No limitation □Slight limitation □Moderate limitation
   □Marked limitation □Severe limitation

8. **Identify the side effects of any medication which may have implications for working, e.g. dizziness, drowsiness, stomach upset, etc.: _____**
_____

9. **Have your patient's impairments lasted, or can they be expected to last, at least twelve months?** □Yes □No

10. **As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed on a competitive work situation:**

a. **Continuously sit** **<1 1 2 3 4 5 6 7 8** **Hours at one time**

b. **Continuously stand** **<1 1 2 3 4 5 6 7 8** **Hours at one time**

c. **Total in an 8-hour working day?**

Sit	**Stand/walk**	
□	□	less than 2 hours
□	□	about 2 hours
□	□	about 4 hours
□	□	at least 6 hours

d. **Mark the degree to which your patient must avoid the following:**

	Avoid No Restriction	**Avoid Concentrated Exposure**	**Avoid Moderate Exposure**	**Avoid All Exposure**
Extreme heat	□	□	□	□
Extreme cold	□	□	□	□
High humidity	□	□	□	□
Solvents/cleaners	□	□	□	□
Chemicals	□	□	□	□
Soldering fluxes	□	□	□	□
Cigarette smoke	□	□	□	□
Perfumes	□	□	□	□
Fumes, dusts, gases	□	□	□	□

11. **Are your patient's impairments likely to produce "good days" and "bad days"?**
□Yes □No

12. **Is your patient a malingerer?** □Yes □No

13. **How long has your patient been functioning at this level? _____**

Date: _____ Signature: _____

Printed/Typed Name: _____