Fibromyalgia Residual Functional Capacity Questionnaire

Name: _____ SSN:_____

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

1. Does your patient meet the American Rheumatological criteria for fibromyalgia? ☐ Yes ☐ No

2. List any other diagnosed impairments?_____

3. Prognosis:_____

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

5. Identify you patient's symptoms:

☐Multiple Tender Points	☐Numbness and Tingling	☐Non restorative sleep
☐Sicca symptoms	☐Chronic fatigue	☐Raynoud's phenomenon
☐Dysmenorrhea	☐Breathlessness	☐Muscle weakness
☐Anxiety	☐Subjective swelling	☐Panic attacks
☐Irritable bowel syndrome	☐Depression	☐Frequent, severe headaches
☐Mitral valve prolapse	☐Female Urethral Syndrome	☐Hypothyroidism
☐Carpal Tunnel Syndrome	☐Vestibular dysfunction	
☐Other_____		

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

7. If your patient has pain: Identify the location of pain including where appropriate, an indication of right and/or left side affected:

	Right	**Left**
☐Shoulders	☐	☐
☐Arms	☐	☐
☐Hands/fingers	☐	☐
☐Hips	☐	☐
☐Legs	☐	☐
☐Knees/ankles/feet	☐	☐

☐Lumbosacral spine ☐Cervical spine ☐Thoracic spine
☐Chest

8. Identify any factors that precipitate pain:

☐Changing weather	☐Fatigue	☐Movement/Overuse
☐Cold ☐Stress	☐Hormonal changes	☐Static position

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

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

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

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

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

14. 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 cant 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

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:_____