Stroke 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:**

□ Balance problems	□ Difficulty thinking & concentrating
□ Ataxia	□ Depression
□ Loss of manual dexterity	□ Difficulty solving problems
□ Weakness	□ Headaches
□ Slight paralysis	□ Emotional lability
□ Difficulty walking	□ Personality change
□ Fainting spells	□ Dizziness & loss of balance
□ Numbness, other sensory disturbance	□ Problems with judgment
□ Pain	□ Headaches
□ Fatigue	□ Blurred vision
□ Bladder problems	□ Partial or complete blindness
□ Nausea	□ Tremor
□ Incontinence	□ Speech & communication difficulties

□ Other _____
_____
_____

4. **Does your patient have significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movement or gait and station?** □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. **How many pounds can your patient lift and carry in a competitive work situation?**

	Never	**Occasionally**	**Frequently**
Less than 10 lbs	□	□	□
10 lbs	□	□	□
20 lbs	□	□	□
50 lbs	□	□	□

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: _____