HEADACHES
RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE

Name:	
Claim #:	
Date of Injury:	

What is the first date at which your patient's impairment(s) became "severe" meaning that his or her impairment(s) caused interference their ADL's or ability to work?	Date:
When did you begin treating the patient?	Date:
How frequently do you see your patient?	Date:

Diagnoses:_____

Does your patient have headaches?	Yes ☐	No ☐

If yes, please characterize the nature, location and intensity/severity (mild to severe) of your patient's headaches:

_____

Identify any other symptoms associated with your patient's headaches:

	Vertigo		Visual Disturbances
	Nausea/Vomiting		Mood Changes
	Malaise		Mental Confusion/Inability to Concentrate
	Photosensitivity		

Other:

What is the average frequency of all headaches?	Approximate x's per day _____ Approximate x's per week_____
What is the average duration of all headaches?	About _____minutes About _____hours
What is the approximate frequency of **severe** headaches?	Approximate x's per day _____ Approximate x's per week_____
What is the approximate duration of **severe** headaches?	About _____minutes About _____hours

What triggers your patient's headaches?

	Alcohol		Lack of Sleep
	Bright Lights		Menstruation
	Noise		Vigorous Exercise
	Stress		Food – identify:
	Strong Odors		
	Hunger		
	Weather Changes		

Other:

What makes your patient's headaches worse?

	Bright Lights		Moving Around
	Coughing, Straining/Bowl Movement		Noise
Other:			

What makes your patient's headaches better?

	Lying in a Dark Room		Finger Pressure/Massage
	Cold/Hot Packs		
Other:			

Identify any positive test results and objective signs of your patient's headaches:

	Weight Loss		X-Ray
	Tenderness		MRI
	Impaired Sleep		CT Scan
	Impaired Appetite or Gastritis		EEG
Other:			

Identify any impairment(s) that could reasonably be expected to explain your patient's headaches:

	Anxiety/Tension		Intracranial Infection or Tumor
	Cerebral Hypoxia		Migraine
	Cervical Disc Disease		Seizure Disorder
	History of Head Injury		Sinusitis
	Hypertension		Substance Abuse
Other:			

To what degree do emotional factors contribute to the severity of your patient's headaches?	Not at all ☐	Somewhat ☐	Very Much ☐

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

Please describe the treatment and response:	_____

Is your patient taking prescribed medication for his/her headache(s):	Yes ☐	No ☐
Side Effects: Please identify side effects of these medications experienced by your patient, if any:		
Please describe the prognosis:		
Have the patient's impairments lasted or can they be expected to last at least twelve months?	Yes ☐	No ☐
During times your patient has a headache would your patient generally be precluded from performing even basic work activities and need a break from the workplace?	Yes ☐	No ☐
If no, please explain:		

Will your patient sometimes need to take unscheduled breaks during an 8-hour working day?	Yes ☐	No ☐
If yes,		
1) How *often* do you think this will happen?		
2) How *long* (on average) will your patient have to rest before returning to work?		
3) On such a break, will your patient need to lie down or sit quietly?		

To what degree can your patient tolerate work stress?

Examples of factors that may precipitate work related stress: maintaining speed; precision; persistence and pace; complexity; meeting deadlines; working within a schedule; making decisions; exercising independent judgment; completing tasks; getting to work regularly; remaining at work for a full day.	
☐ Incapable of "low stress" jobs	☐ Capable of low stress jobs
☐ Moderate stress is okay	☐ Capable of high stress work
Will claimant's impairments likely to produce **"good days"** and **"bad days"?** ☐ Yes ☐ No ☐ Other:	
If yes, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of headaches or treatment for headaches?	
☐ Never	☐ About three days per month
☐ About one day per month	☐ About four days per month
☐ About two days per month	☐ More than four days per month

Please consider the following functions within the context of your patient's capacity to sustain the activity over a normal workday and workweek, on an ongoing basis. If appropriate and by analogy, utilize degrees of functional loss classified in chapter 14.3e "Class of Impairments Due to Mental and Behavioral Disorders":

1. None means no impairment is noted in the functions.
2. Mild implies that any discerned impairment is compatible with most useful functioning.
3. Moderate means that the identified impairments are compatible with some, but not all, useful functioning.
4. Marked is a level of impairment that significantly impedes useful functioning. Taken alone, a marked impairment would not completely preclude functioning, but together with marked limitation in another class, it might limit useful functioning.
5. Extreme means that the impairment or limitation is not compatible with useful function.

On average how will headaches affect your patient's ability to perform the following functions?

SUSTAINED PERSISTENCE AND PACE						
	None	Mild	Moderate	Marked	Extreme	Insufficient Evidence
Carry out very short and simple instructions.	☐	☐	☐	☐	☐	☐
Ability to perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances.	☐	☐	☐	☐	☐	☐
Ability to sustain an ordinary routine without special accommodations.	☐	☐	☐	☐	☐	☐
Ability to work in coordination with or proximity to others without being distracted by them.	☐	☐	☐	☐	☐	☐
Ability to make simple work-related decisions.	☐	☐	☐	☐	☐	☐

	None	Mild	Moderate	Marked	Extreme	Insufficient Evidence
Ability to complete a normal workday and workweek without interruptions due to headaches and to perform at a consistent pace without an unreasonable number and length of rest periods.	☐	☐	☐	☐	☐	☐

On average how will headaches affect your patient's ability to perform the following functions requiring sustained concentration?

SUSTAINED CONCENTRATION						
	None	Mild	Moderate	Marked	Extreme	Insufficient Evidence
Ability to read.	☐	☐	☐	☐	☐	☐
Ability to write.	☐	☐	☐	☐	☐	☐
Ability to use a computer.	☐	☐	☐	☐	☐	☐
Ability to use a 10 key.	☐	☐	☐	☐	☐	☐
Ability to perform simple math.	☐	☐	☐	☐	☐	☐
Ability to learn new procedures.	☐	☐	☐	☐	☐	☐
Ability to maintain attention and concentration.	☐	☐	☐	☐	☐	☐
Ability to communicate effectively.	☐	☐	☐	☐	☐	☐
Ability to carry out repetitive and prolonged activities.	☐	☐	☐	☐	☐	☐
Ability to carry out detailed instructions.	☐	☐	☐	☐	☐	☐
Ability to drive.	☐	☐	☐	☐	☐	☐

Please describe any other limitations (such as limitations in the ability to sit, stand, walk, lift, bend, stoop, crouch, limitations in using arms, hands, fingers, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis due to his/her headaches:

_____

_____

I declare under penalty of perjury that the information contained in this report and its attachments, if any, is true and correct to the best of my knowledge and belief, except as to information that I have indicated I received from others. As to that information, I declare under penalty of perjury that the report accurately describes the information provided to me and except as noted herein, that I believe it to be true. I also declare under the perjury that this physician has no violated section 139.3 of the Labor Code.

My opinions are expressed to a degree of medical probability, unless otherwise stated.

Signature of Physician_____ Date _____