

**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:

Does your patient have headaches? Yes No

If yes, please characterize the average intensity/severity (mild, mild to moderate, moderate, moderate to severe or severe) of your patient's headaches:

Please characterize your patient's most severe headaches: (mild, mild to moderate, moderate, moderate to severe or severe)

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 the most severe headaches?	Approximate x's per day _____ Approximate x's per week _____
What is the approximate duration of the most severe headaches?	About _____ minutes About _____ hours

Lie Down/RECLINE

Is there a reasonable medical probability that claimant will need to take lie down or recline to relieve or control the most severe headache pain? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
If claimant needs to lie down or recline to relieve or control the most severe headache pain can you estimate for how <i>often</i> and for <i>how long</i> he or she may have to do so? About _____ minutes; every _____ hour(s)

UNSCHEDULED BREAKS

Is there a reasonable medical probability that claimant will need to take unscheduled breaks during the workday due to headache pain? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Other:
If claimant needs to take unscheduled breaks to relieve or control headache pain can you estimate how <i>often</i> and for how long he or she may have to do so? About _____ minutes; every _____ hour(s)

How often during a typical workday will claimant experience headache pain severe enough to interfere with <i>attention and concentration</i> needed to perform simple work tasks as a result of the combination of impairments?				
Not at all	Rare 1-5% day	Occasionally up to 1/3 rd day	Frequently 1/3 rd to 2/3 rd day	Continuously 2/3 rd day or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
How often during a typical workday will the combination of claimant’s headache pain interfere with an ability to perform <i>sustained and competitive work</i> ?				
Not at all	Rare 1-5% day	Occasionally up to 1/3 rd day	Frequently 1/3 rd to 2/3 rd day	Continuously 2/3 rd day or more
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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”:

Degrees of Functional Limitations defined:

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.

If appropriate, please choose one of the following definitions of “**off task**” for “**Moderate restriction**” you feel best describes your patient’s **loss of useful function** expressed as percentile:

1. “Off task” 10% of the time over the course of an 8 hour day due to headaches;
2. “Off task” 15% of the time over the course of an 8 hour day due to headaches;
3. “Off task” 20% of the time over the course of an 8 hour day due to headaches;
4. “Off task” 25% of the time over the course of an 8 hour day due to headaches;
5. “Off task” ____% of the time over the course of an 8 hour day due headaches;

Assume that “off task” means an inability to perform the activity and/or a reduction in productivity over the course of an 8 hour work day.

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.	<input type="checkbox"/>					
Ability to perform activities within a schedule, maintain regular attendance and be punctual within customary tolerances.	<input type="checkbox"/>					
Ability to sustain an ordinary routine without special accommodations.	<input type="checkbox"/>					

	None	Mild	Moderate	Marked	Extreme	Insufficient Evidence
Ability to work in coordination with or proximity to others without being distracted by them.	<input type="checkbox"/>					
Ability to make simple work-related decisions.	<input type="checkbox"/>					
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.	<input type="checkbox"/>					

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.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to write.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to use a computer.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to use a 10 key.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to perform simple math.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to learn new procedures.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to maintain attention and concentration.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to communicate effectively.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to carry out repetitive and prolonged activities.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to carry out detailed instructions.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Ability to drive.	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Is it reasonable to expect claimant’s headache pain, as described above, to increase at times spontaneously, unpredictably and/or without provocation?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
During times your patient has the most severe headache pain would he or she generally be precluded from performing basic work activities and need a break from the workplace?					<input type="checkbox"/> Yes	<input type="checkbox"/> No
If no, please explain:						
Will claimant’s impairments likely to produce “good days” and “bad days”? <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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?						
<input type="checkbox"/>	Never	<input type="checkbox"/>	About three days per month			
<input type="checkbox"/>	About one day per month	<input type="checkbox"/>	About four days per month			
<input type="checkbox"/>	About two days per month	<input type="checkbox"/>	More than four days per month			

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 _____