

RESIDUAL FUNCTIONAL CAPACITY CERVICAL SPINE

Name:																
Claim #:																
Date of Injury:																
Please Print Name of Medical Evaluator:																
Medical Specialty:																
Has any medication and/or treatment necessary to relieve and/or control pain of the underlying condition(s) been denied?												Yes <input type="checkbox"/>		No <input type="checkbox"/>		
If yes, has the claimant's functionality decreased as a result of the denials?												Yes <input type="checkbox"/>		No <input type="checkbox"/>		
Does claimant experience any side effects from the medication(s) that has not been denied?												Yes <input type="checkbox"/>		No <input type="checkbox"/>		
Given the aforementioned and within a reasonable degree of medical probability please address the following questions:																
Can the claimant reasonably be expected to engage in sustained competitive work 8 hours a day 5 days a week considering the totality of his/her functional limitations?												Yes <input type="checkbox"/>		No <input type="checkbox"/>		
How many hours can claimant reasonably expect to sustain competitive work if vocationally and medically compatible work is identified? Hour(s) each day:								<1	1	2	3	4	5	6	7	8
Are assistive device(s) medically required and/or prescribed?												Yes <input type="checkbox"/>		No <input type="checkbox"/>		
Arm Brace(s)		Back Brace		Walker		Cane		Wheel Chair		Scooter		High back chair		Other:		
The claimant's dominant extremity is:								Right <input type="checkbox"/>				Left <input type="checkbox"/>				
NECK/HEAD/CERVICAL REGION (check capacity for each activity)																
Physical Activity	(# of hours in an 8-hour day)								Duration/Tolerance minutes							
	<1	1	2	3	4	5	6	7	8	<5 min	5-10	11-15	16-20	21-30	31-45	46-60
Neck Flexion/ Extension																
Neck Rotation																
Can episodes of pain become <i>moderate, moderate to severe, or severe</i> ? [Circle one or more]												Yes <input type="checkbox"/>		No <input type="checkbox"/>		
Other:																
Is it reasonable to expect claimant's pain, as described above, to increase at times spontaneously, unpredictably and/or without provocation?												Yes <input type="checkbox"/>		No <input type="checkbox"/>		
If yes, how often?																
If spontaneous spikes in pain occur as described above, how long can they be expected to last out of an 8 hour work day or its equivalent: 5% of the day; 10% of the day; 15% of the day, 20% of the day; Other _____% of the day																
CERVICOGENIC HEADACHES																
Is there a medical probability that your patient's cervical condition will cause headaches?												Yes <input type="checkbox"/>		No <input type="checkbox"/>		
On average please characterize your patient's headaches in terms of intensity/severity; minimum, slight, moderate, moderate/ severe, severe or other:																
Identify any other symptoms associated with your patient's headaches:																
Vertigo				Visual Disturbances												
Nausea/Vomiting				Mood Changes												
Malaise				Mental Confusion/Inability to Concentrate												
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; _____ 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 _____ hours
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 <input type="checkbox"/> No <input type="checkbox"/>

UPPER EXTREMITY USE WITH MULTIPLE LEVEL CERVICAL FUSION

Is there a medical probability that the cervical condition will cause problems with your patient's upper extremities?	Yes <input type="checkbox"/> No <input type="checkbox"/>
If yes, which is the affected extremity:	Right <input type="checkbox"/> Left <input type="checkbox"/> Both <input type="checkbox"/>

Identify any signs or symptoms your patient exhibits that affect shoulders, elbows, wrists, hands or fingers:					
<input type="checkbox"/> Tenderness	<input type="checkbox"/> Paresthesia	<input type="checkbox"/> Joint warmth			
<input type="checkbox"/> Pain	<input type="checkbox"/> Soft tissue swelling	<input type="checkbox"/> Joint deformity			
<input type="checkbox"/> Muscle spasm	<input type="checkbox"/> Muscle weakness	<input type="checkbox"/> Reduced grip strength			
<input type="checkbox"/> Redness	<input type="checkbox"/> Limitation of motion	<input type="checkbox"/> Muscle atrophy			
	Not at all	Rare 1-5% day	Occasionally up to 1/3rd day	Frequently 1/3rd to 2/3rd day	Continuously 2/3 rd day or more

REACHING: Over shoulder(s)/head											
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	

REACHING: Below shoulder(s)											
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	

HANDLING: Seizing, holding, grasping, turning, or otherwise working with hand or hands. Fingers are involved only to the extent that they are an extension of the hand, such as to turn a switch or shift automobile gears.											
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	

FINGERING: Picking, pinching, or otherwise working primarily with fingers rather than with the whole hand or arm as in handling.											
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	

Estimate the time in an 8-hour work day claimant can use hands/fingers/arms for the following activities:											
	Right	Left	Right	Left	Right	Left	Right	Left	Right	Left	
Simple Grasping											
Fine Manipulation											
Repetitive activities											

EXERTIONAL PHYSICAL DEMANDS: (SIT, STAND, WALK)

Estimate # of hours of a work day, 8 hours or otherwise, can claimant be expected to sustain competitive work:										
	<1	1	2	3	4	5	6	7	8	
Sit										
Stand										
Walk										

EXERTIONAL PHYSICAL DEMANDS: (LIFT, CARRY, PUSH AND PULL)

	LIFT with RIGHT				
	Not at all	Rarely 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
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
	LIFT with LEFT				
	Not at all	Rarely 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
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
	CARRY with RIGHT				
	Not at all	Rarely 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
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
	CARRY with LEFT				
	Not at all	Rarely 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
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					
	PUSH/PULL				
	Not at all	Rarely 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
< 10 pounds					
10 pounds					
11-20 pounds					
21-25 pounds					

NON-EXERTIONAL PHYSICAL DEMANDS

	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
Climb Stairs					
Balance					
Stoop					
Crouch					
Claimant is restricted from activities involving: (check capacity for each activity)					
		Restricted	Unrestricted	Comments	
Hazards (moving machinery, heights)					
Driving Automotive Equipment					
Exposure to Dust, Fumes, Gases					
Changes in Temperature					
Extreme heat					
Extreme cold					
Humidity					
Wetness					
Vibration					

REASONABLE ACTIVITIES TO CONTROL AND/OR RELIEVE PAIN

What is the most effective manner for claimant to control or manage his/her pain?									
<input type="checkbox"/> Take Medications <input type="checkbox"/> Apply TENS Unit <input type="checkbox"/> Lie Down <input type="checkbox"/> Recline <input type="checkbox"/> Rest			<input type="checkbox"/> Apply hot/cold packs <input type="checkbox"/> Alternate positions <input type="checkbox"/> Avoid prolonged activities <input type="checkbox"/> Use of supports <input type="checkbox"/> Avoid offending activities			Other:			
Allowance to alternate positions:									
A. Will claimant need an allowance to alternate positions at will?						Yes <input type="checkbox"/>	No <input type="checkbox"/>	Comments:	
B. Will the allowance to alternate positions include the ability to sit, stand, and walk even if only a few steps and/or stretch?						Yes <input type="checkbox"/>	No <input type="checkbox"/>		
C. Please estimate the number of minutes and/or hours claimant is able to sit, stand, or walk <i>at one time without interruption</i> before needing to alternate or change positions:									
Minutes/hours	<5	Up to 5min	Up to 10min	Up to 15min	Up to 20min	Up to 30min	Up to 45min	Up to 1 hour without a break	Up to 2 hours without a break
Sitting									
Walking									
Standing									
D. Please estimate the length of time needed before claimant can resume sitting, standing and walking									
	<1 min	Up to 5 min	Up to 10 min	Up to 15 min	Other:				
Sitting					Other:				
Walking					Other:				
Standing					Other:				

LIE DOWN/RECLINE

Is there a reasonable medical probability that claimant will need to take lie down or recline during the workday to relieve or control pain? Yes No Other:

If claimant needs to lie down or recline to relive or control pain can you estimate how *often* and for *how long* 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? Yes No Other:

If claimant needs to take unscheduled breaks to relieve or control pain can you estimate how *often* 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 fatigue or other symptom severe enough to interfere with **attention and concentration** needed to perform even 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 impairments interfere with an ability to perform **sustained and competitive work**?

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"/>

To what degree can claimant tolerate **work stress** as a result of the medical condition(s)?

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.

<input type="checkbox"/> Incapable of “low stress” jobs	<input type="checkbox"/> Capable of low stress jobs
<input type="checkbox"/> Moderate stress is okay	<input type="checkbox"/> 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 average, how many days per month claimant is likely to be absent from work as a result of the impairments or treatment?

<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

If not already addressed in prior reports, please provide objective findings, diagnostic test results and diagnoses and all other pertinent factors that support your responses to this questionnaire.

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 _____

Additional Comments: _____