HEADACHES
RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE

Name:			
Claim #:			
Date of Injury:			
Medical Specialty:			
Has any medication and/or treatment necessary to relieve and/or control pain of the underlying condition(s) been denied?		Yes☐	No☐
If yes, has the claimant's functionality decreased as a result of the denials?		Yes☐	No☐
Does claimant experience any side effects from the medication(s) that has not been denied?		Yes☐	No☐
What is the first date at which the claimant'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:		
Given the aforementioned and within a reasonable degree of medical probability please address the following questions:			
Does the claimant have headaches?	Yes☐	No☐	
If yes, what ***type*** of headache does the claimant have?	☐ Migraine ☐ Vascular tension ☐ Cluster ☐ Post-concussion syndrome ☐ Other		

Identify any other symptoms associated with the claimant's headaches		
☐ fatigue	☐ general malaise	☐ irritability
☐ difficulty walking	☐ muscle weakness	☐ loss of manual dexterity
☐ episodic vision blurriness	☐ sound sensitivity	☐ diarrhea
☐ nausea / vomiting	☐ light sensitivity	☐ vertigo / loss of balance
☐ phonophobia	☐ impaired appetite	☐ throbbing pain
☐ visual disturbances	☐ mental confusion	☐ weight change
☐ mood changes	☐ impaired sleep	☐ sensitivity to smells
☐ exhaustion	☐ dull stabbing pain	☐ inability to concentrate
☐ other		

What makes the claimant's headaches worse?	☐ Bright lights ☐ Coughing, straining/bowel movement ☐ Moving around ☐ Noise ☐ Other
What makes the claimant's headaches better?	☐ Lie down ☐ Take medication ☐ Quiet place ☐ Dark room ☐ Hot pack

	☐ Cold pack ☐ Other
Please characterize on <u>average</u> the intensity/severity of the claimant's headaches: (mild, mild to moderate, moderate, moderate to severe or severe)	
Please characterize the claimant's most <u>severe</u> headaches: (mild, mild to moderate, moderate, moderate to severe or severe)	
What is the <u>average</u> frequency of <u>all</u> headaches?	Approximate x's per day _____ Approximate x's per week_____
What is the <u>average</u> duration of <u>all</u> headaches?	About _____minutes About _____hours
What is the approximate frequency of the most <u>severe</u> headaches?	Approximate x's per day _____ Approximate x's per week_____
What is the approximate duration of the most <u>severe</u> 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? ☐ Yes ☐ No ☐ Other:
If claimant needs to lie down or recline to relieve or control the most severe headache pain can you estimate for 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 due to headache pain? ☐ Yes ☐ No ☐ Other:
If claimant needs to take unscheduled breaks to relieve or control headache 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 headache pain severe enough to interfere with ***attention and concentration*** needed to perform simple work tasks as a result of the combination of impairments?

Not at all	**Rare** 1-5% day	**Occasionally** up to 1/3rd day	**Frequently** 1/3rd to 2/3rd day	**Continuously** 2/3rd day or more
☐	☐	☐	☐	☐

How often during a typical workday will the combination of claimant's headache pain interfere with an ability to perform ***sustained and competitive work***?

Not at all	**Rare** 1-5% day	**Occasionally** up to 1/3rd day	**Frequently** 1/3rd to 2/3rd day	**Continuously** 2/3rd day or more
☐	☐	☐	☐	☐

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"** 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.	☐	☐	☐	☐	☐	☐
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.	☐	☐	☐	☐	☐	☐
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 the claimant'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	☐	☐	☐	☐	☐	☐
Is it reasonable to expect claimant's headache pain, as described above, to increase at times spontaneously, unpredictably and/or without provocation?					Yes☐	No☐
During times the claimant 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?					Yes☐	No☐
If no, please explain:						
Will claimant's impairments likely produce **"good days"** and **"bad days"?** ☐ Yes ☐ No ☐ Other:						
If yes, please estimate, on the average, how many days per month the claimant is likely to be absent from work as a result of headaches or treatment for headaches?						
☐ Never ☐ About one day per month ☐ About two days per month			☐ About three days per month ☐ About four days per month ☐ 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 _____