PHYSICAL CAPACITIES EVALUATION FORM/RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT FORM

ACTUAL SAMPLE *(Note: This is an example of the specificity with which this form should be completed to be useful for the Social Security Administration's determination of an Applicants eligibility for Disability. Please note the combination of observable subjective comments, coupled with objective, documented tests of Applicant's diagnoses.)*

Patient: Jane Smith SS #: XXX-XX-XXXX

Date of Birth: YY-YY-YYYY

Dear Doctor:

Please answer the following questions with regard to your patient's claim for Social Security disability benefits or Supplemental Security Income (SSI) and/or with regard to your patient's claim for Long Term Disability (LTD). **Please base your answers SPECIFICALLY AND IN DETAIL on how your patient's medical conditions affect his or her ability to function while conducting his/her normal daily activities, whether at home or at work.**

1. Nature, frequency and length of contact: I have been Jane's Primary Care Doctor since 1987. I see her at least twice a year, for check-ups for her Multiple Sclerosis. I see her more often, for other reasons.

2. Please describe patient's symptoms (including patient's reports of pain, dizziness, etc.): Please refer to Patient's attached Matrices (Symptom Impairment Matrix and Before and After matrix). Also, please refer to her MS History, also attached. *(NOTE: if you have not completed this document, it is available in the DisabilityKey Workbook, available for sale at under $10.00 at the www.disabilitykey.com website. It GREATLY decreases the*

time/effort you and your doctors have to take when completing this document!)

3. State all clinical findings and laboratory/test results (or enclose copy of same): **Please link findings to specific limitations**. Attached is a copy of patient's Spinal Tap results, with the specific finding related to MS highlighted. Attached also is copy of a document describing how to interpret the Spinal Tap findings if they result in a determination of MS. The patient's conclusive diagnosis of MS came not only from this test, but from my clinical observations, and from those of her Eye Doctor, attesting to the visual problems. The link of these findings to the patient's specific limitations on her normal daily activities can be found in the documents attached described in question #2.

4. Diagnosis: Secondary progressive Multiple Sclerosis.

5. Treatment and response (including list of medications and their effect and side-effects): Please refer to attached chart notes and to attachments already described in #2.

6. Prognosis: Patient's Progress continues a steady decline. She rates a 6.5 on the standard EDSS scale; she cannot perform any gainful work; her condition is predicted to continue indefinitely.

7. Has the patient's impairment lasted, or can it be expected to last, at least twelve months?
Yes __X___ No _____

8. Can the patient continuously stand for at least 6 of 8 hours?
Yes __X___ No _____ How long CAN the patient stand? About 10 minutes at a time without assistance. About 20 minutes at a time with assistance (i.e., 2 crutches). Time assessed during office visit.

9. Can the patient continuously sit upright for at least 6 of 8 hours?
Yes _____ No ___X___
How long CAN the patient sit upright? About 30 minutes, every three or so

hours when awake. Patient sleeps at least, 10, and often 12 hours per day. Timing measured by patient at home, with assistance from family.

10. If the answer to either number 8 or number 9 is NO, why is the patient unable to sit or stand? Please refer to the attached documents that completely explain IN GREAT DETAIL why the patient is unable to sit or stand for significant periods of time. In general, she cannot sit or stand for significant periods of time because of her muscle, nerve, balance, coordination, and fatigue problems.

11. Does the patient have to lie down during the day? Yes __X____ No _____
If yes, please explain why: As explained in great detail in the attached, patient's fatigue, muscle, balance, coordination, and other problems require her to sleep for 10 – 12 hours per day. In addition, she rests or naps or reclines for 30 – 40 minutes of each hour she is not asleep.

12. How many city blocks can the patient walk without stopping? With her walking assists (2 canadian canes and/or walker) one short block (4 – 6 houses).

Please check the frequency that the patient can perform the following activities:

	Rarely	Freq.	Const.
	0-33%	34-67%	68-100%
Reach Above shoulder	___X___	_____	_____
At waist level	___X___	_____	_____
Below waist level	___X___	_____	_____
Handling (gross motor)	___X___	_____	_____
Fingering (fine motor)	___X___	_____	_____

Feeling ___X___ _____ _____

14. How many pounds can the patient frequently lift over an 8 hour period?
__X___ Less than 5 _____5-10 _____11-20 _____21-50 _____over 50

15. How many pounds can the patient frequently carry?
__X__ Less than 5 _____5-10 _____11-20 _____21-50 _____over 50

16. Does the patient have any problems performing such functions as grasping, pulling, pushing, or doing fine manipulations with his or her hands? PLEASE **BE SPECIFIC.** Again as indicated in the attachments, patient has significant problems grasping, pulling, and pushing, due to the increasing numbness in both hands. In addition, the left hand in particular, has been both "freezing-up" and twitching, making utilization iffy at best. The brain lesions of patient are interfering with fine motor coordination and manipulations. Her handwriting has significantly changed. She primarily types now, and each document takes 3 – 4 times longer than during her work life. And, she has problems with left and right hand lettering accuracy.

17.Does the patient have any problems with the following movements? (Please indicate any applicable range of motion studies):

Bending _____yes_____
Squatting _____yes_____
Kneeling _____yes_____
Turning any parts of the body _____yes_____
Bi-annual observation; neurological assessments during office visits; medication taken for muscle relaxation and tremor control.

18. Is the patient able to travel alone? Yes _____ No ___X___Why? Patient has lost her ability to drive. Traveling alone would be impossible due to all of the physical impairments – particularly fatigue – depicted in the attachments.

19. Are there any other factors affecting the patient's ability to work (e.g. exposure to fumes, gases; ability to tolerate heights; restriction of exposure to moving machinery)?
The combined factors affecting patient's ability to work adequately depicted in the attached, plus my diagnosis that her condition will continue indefinitely, all affect her ability to perform work of any kind. *(Once again, this Matrix, called the Before and After Matrix, are contained in the DisabilityKey Workbook, available at the www.disabilitykey.com website. This matrix again describes and contrasts, in great detail the patient's normal daily activities both at work and home.)*

20. If your patient complains of any pain, please indicate the nature and severity of the complaints and your opinion of the patient's credibility with respect to his or her complaints: Patient's pain is constant, to some degree or another. Medications allow her to function at the minimal level depicted in the attached. I rate her credibility with respect to her complaints excellent.

If there is an objective basis for the patient's pain, give specific details for this basis (i.e. degenerative changes in the spine): Please see attached two Matrices.

21. Considering your diagnosis of the patient's condition and his/her prognosis, is the patient capable of returning to his/her past job?

Yes _____ No ___X__ State why or why not: Adequately covered in other questions and in the attached.

22. Considering the same factors, is there any work the patient is capable of? State why or why not: No; adequately answered in other questions and in the attached.

Please note whether the above restrictions are:

__X__ Not likely to change.

____Temporary From:_____To:_____

Date patient can return to work:_____

_____Without Restrictions

_____With Restrictions as noted above

Please enclose copies of your clinical records on this patient. Use the space below for any additional comments you may have:

Date Report Completed:_____

Signature of Physician:_____

Physician Name:_____

Address:_____

Telephone:_____

Specialty:_____