Residual Functional Capacities Form (Physical)

Name: **SSN:**

Please complete the following items based on your clinical evaluation of the above named patient/claimant. Any item you do not believe you can assess should be marked N/A.

In an 8 hour workday, the patient/claimant can: [Circle full capacity for activity]

		Continuously	**With Rests**
Sit	1 2 3 4 5 6 7 8 [hrs]	____	____
Stand	1 2 3 4 5 6 7 8 [hrs]	____	____
Walk	1 2 3 4 5 6 7 8 [hrs]	____	____

	Never	**Occasionally** [1% - 33%]	**Frequently** [34% - 66%]	**Continuously** [67% - 100%]
Lift:				
10 lbs.	____	____	____	____
11-20 lbs	____	____	____	____
21-50 lbs.	____	____	____	____
51-100 lbs.	____	____	____	____
Carry:				
10 lbs.	____	____	____	____
11-20 lbs.	____	____	____	____
21-50 lbs.	____	____	____	____
51-100 lbs.	____	____	____	____
Bend:	____	____	____	____
Squat:	____	____	____	____
Crawl:	____	____	____	____
Climb:	____	____	____	____
Reach above shoulder level:	____	____	____	____

Patient/Claimant can use hands for repetitive actions:

	Simple Grasping		Pushing/Pulling		Fine Manipulating	
	Yes	**No**	**Yes**	**No**	**Yes**	**No**
Right:	____	____	____	____	____	____
Left:	____	____	____	____	____	____

Patient/Claimant can use feet for repetitive movements as in operating foot controls:

	Yes	**No**
Right:	____	____
Left:	____	____

Restriction of activities involving:

	None	**Mild**	**Moderate**	**Heavy**
Unprotected heights:	____	____	____	____
Being around moving machinery:	____	____	____	____
Exposure to marked change in temperature and humidity:	____	____	____	____
Driving automobile equipment:				
Exposure to dust, fumes, & gases:	____	____	____	____

	Yes	**No**
Can patient/claimant now participate in substantial gainful activity?	____	____
If not, will above conditions and disability last in excess of 12 months?	____	____

Comments:_____
_____

Physician's Signature_____ Date:_____

Physician's Name [Type or print]:_____