Residual Functional Capacity Questionnaire
CERVICAL SPINE

Patient: _____________________________________________________________________________

DOB: ______________________________________________________________________________

Physician completing this form: ________________________________________________________

Please complete the following questions regarding this patient's impairments and attach all supporting
treatment notes, radiologist reports, laboratory and test results.

Symptoms & Diagnosis

What diagnoses has this patient received? _________________________________________________
____________________________________________________________________________________

Describe the patient's symptoms, such as pain, dizziness, fatigue, etc. ______________________
____________________________________________________________________________________
____________________________________________________________________________________

Does the patient have chronic pain/paresthesia?  □ Yes  □ No

Describe the patient's type of pain, location, frequency, precipitating factors, and severity. ________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Please indicate all positive objective signs exhibited by the patient:

□ Abnormal posture  □ Atrophy  □ Chronic fatigue  □ Crepitus
□ Drops things  □ Joint Swelling  □ Joint Redness  □ Joint Warmth
□ Impaired appetite  □ Impaired sleep  □ Lack of coordination  □ Motor loss
□ Muscle spasm  □ Muscle weakness  □ Reduced grip strength  □ Reflex changes
□ Sensory changes  □ Spastic gait  □ Spastic gait  □ Swelling
□ Tenderness  □ Weight change
□ Other: ______________________
____________________________________________________________________________________
____________________________________________________________________________________

Does the patient have significant limitation of motion?  □ Yes  □ No

If yes, please indicate cervical range of motion:

Extension _______%  Flexion _______%
Left Rotation _______%  Right Rotation _______%
Left Lateral Bending _______%  Right Lateral Bending _______%

Does the patient experience severe headaches associated with the cervical spine?  □ Yes  □ No

If yes, how often do these headaches occur? _____ per week _____ per month

How long does a typical headache last? _____ minutes _____ hours

Mark any remedies that minimize the patient's headaches

□ Cold Pack  □ Darkness  □ Hot Pack
□ Lie Down  □ Medication  □ Silence
□ Other: ______________________
____________________________________________________________________________________
Please indicate other symptoms associated with the patient’s headaches.

☐ Exhaustion  ☐ Impaired appetite  ☐ Impaired sleep  ☐ Inability to concentrate
☐ Malaise  ☐ Mental confusion  ☐ Mood changes  ☐ Nausea/vomiting
☐ Photosensitivity  ☐ Vertigo  ☐ Visual disturbances  ☐ Weight change
☐ Other: ________________________________________________________________

What is the earliest date that the above description of limitations applies? ________________________________

Have these symptoms lasted (or are they expected to last) twelve months or longer?  ☐ Yes  ☐ No

Are these physical and emotional impairments reasonably consistent with the patient’s symptoms and functional limitations?  ☐ Yes  ☐ No

If no, please explain: __________________________________________________________________________
________________________________________________________________________________________

Testing & Treatments

Identify any positive clinical findings and test results: ________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

List all attempted treatments and medications, the patient’s response, and exhibited side effects.
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Please list the patient’s current medications: _____________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

Please indicate the treatment type, start dates, and frequency: ______________________________________
________________________________________________________________________________________
________________________________________________________________________________________
________________________________________________________________________________________

What is the patient’s prognosis? _________________________________________________________________

Is this patient a malingerer?  ☐ Yes  ☐ No
**Functional Work Limitations**

When answering the following questions, please consider this patient’s impairments and estimate his or her ability to work in a competitive work environment for an 8-hour shift with normal breaks.

How often do you expect this patient’s pain or symptoms to interfere with the attention and concentration necessary to perform simple work tasks?
- ☐ Never
- ☐ Rarely (1% to 5% of an 8 hour working day)
- ☐ Occasionally (6% to 33% of an 8 hour working day)
- ☐ Frequently (34% to 66% of an 8 hour working day)
- ☐ Constantly

How well do you expect this patient to be able to tolerate work stress?
- ☐ Incapable of even "low stress" jobs
- ☐ Only capable of low stress jobs
- ☐ Moderate stress is okay
- ☐ Capable of high stress situations
- ☐ Explain: ________________________________________________________________

Is this patient taking any medications with side effects that may affect his or her ability to work?
- ☐ Yes ☐ No
- ☐ If yes, please list possible side effects. ________________________________________________________________

How far can this patient walk without rest or severe pain? __________________________________________

How long can this patient sit comfortably at one time before needing to get up?
- Minutes: 0 5 10 15 20 30 45
- Hours: 1 2 Longer than 2
- What must the patient usually do after sitting this long?
  - ☐ Stand ☐ Walk ☐ Lie Down ☐ Other: __________________________

How long can this patient stand comfortably at one time before needing to sit or walk around?
- Minutes: 0 5 10 15 20 30 45
- Hours: 1 2 Longer than 2
- What must the patient usually do after sitting this long?
  - ☐ Sit ☐ Walk ☐ Lie Down ☐ Other: __________________________

How long can this patient sit in an 8-hour working day?
- ☐ less than 2 hours
- ☐ about 2 hours
- ☐ about 4 hours
- ☐ at least 6 hours

How long can this patient stand and/or walk in an 8-hour working day?
- ☐ less than 2 hours
- ☐ about 2 hours
- ☐ about 4 hours
- ☐ at least 6 hours

Does this patient need to include periods of walking in an 8-hour working day?
- ☐ Yes ☐ No
  - If yes, how often? 5 10 15 20 30 45 60 90 minutes
  - For how many minutes? 1 2 3 4 5 6 7 8 9 10 11 12 13 14 15

Does this patient require a job that allows the opportunity to change between sitting, standing and walking at will?
- ☐ Yes ☐ No

Does this patient require unscheduled breaks?
□ Yes □ No
If yes, how often?

During this time, this patient will need to □ lie down □ rest head on high back chair □ other
(describe)______________________________ for ______________ minutes.

With prolonged sitting, should this patient’s leg(s) be elevated?
□ Yes □ No
If yes, for what percentage of time in an 8-hour day? ______%  

During occasional standing/walking, does this patient require a cane or other assistive device?
□ Yes □ No

How many pounds can this patient lift and carry?  
Less than 10 lbs. □ Never □ Rarely □ Occasionally □ Frequently  
10 lbs. □ Never □ Rarely □ Occasionally □ Frequently  
20 lbs. □ Never □ Rarely □ Occasionally □ Frequently  
50 lbs. □ Never □ Rarely □ Occasionally □ Frequently  

How often can your patient perform the following activities?
□ Never □ Rarely □ Occasionally □ Frequently  
Twist □ □ □ □  
Stoop (bend) □ □ □ □  
Crouch □ □ □ □  
Climb ladders □ □ □ □  
Climb stairs □ □ □ □  
Hold head in static position □ □ □ □  
Look down □ □ □ □  
Look up □ □ □ □  
Turn head left or right □ □ □ □  

Does this patient have significant limitations with repetitive reaching, handling or fingering?
□ Yes □ No
If yes, please indicate the percentage of time this patient can perform the following activities:
Using hands to grasp, turn and twist objects Right ______% Left ______%  
Using fingers for fine manipulation Right ______% Left ______%  
Using arms to reach out and overhead Right ______% Left ______%  

Are this patient’s impairments likely to produce “good days” and “bad days”?
□ Yes □ No
If yes, please estimate, on average, how many days per month your patient is likely to be absent
from work as a result of the impairments or treatment:
□ Never □ About three days per month  
□ About one day per month □ About four days per month  
□ About two days per month □ More than four days per month  

Please describe any other limitations that might affect this patient’s ability to work at a regular job on a
sustained basis, such as psychological issues, limited vision or hearing, or the inability to adjust to
temperature, wetness, humidity, noise, dust, fumes, gases or hazards, etc.  
____________________________________________________________________________________ 
____________________________________________________________________________________ 
____________________________________________________________________________________  

____________________________________________________________________________________
Please describe additional tests or clinical findings not described on this form that clarify the severity of the patient's impairments.

____________________________________________________________________________________

____________________________________________________________________________________

____________________________________________________________________________________

Completed by:

_________________________  __________________________
Physician's Printed Name  Physician's Signature

___________________________________  __________________________
Address  Date