Residual Functional Capacity Questionnaire  
MULTIPLE SCLEROSIS

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**

Does this patient have multiple sclerosis?  □ Yes  □ No
If yes, how was the diagnosis made?________________________________________________________

What other 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:

- Balance problems
- Depression
- Double/Blurred vision
- Numbness or tingling
- Partial/Complete blindness
- Rapid eye movement
- Shaking tremor
- Unstable walking
- Bladder problems
- Difficulty remembering
- Fatigue
- Poor coordination
- Sensitivity to heat
- Speech/communication difficulties
- Bowel problems
- Difficulty solving problems
- Increased muscle tension (spasticity)
- Paralysis
- Problems with judgment
- Sensory disturbance
- Other: ____________________________

Does your patient complain of a type of fatigue that is best described as lassitude rather than fatigue of motor function?  □ Yes  □ No
If yes, is this kind of fatigue complaint typical of M.S. patients?  □ Yes  □ No

Does your patient have significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movement or gait and station?  □ Yes  □ No
If yes, please describe the degree of interference with locomotion and/or interference with the use of fingers, hands and arms: ____________________________
Does your patient have significant reproducible fatigue of motor function with substantial muscle weakness on repetitive activity, demonstrated on physical examination?  □ Yes  □ No

If yes, describe the activity and the severity of the resulting muscle weakness: ____________________________________________
__________________________________________
__________________________________________

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

Please list the approximate dates of exacerbations of multiple sclerosis during the past year: ______________
________________________________________________________
________________________________________________________
________________________________________________________

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

Are this patient’s symptoms and functional limitations impacted by emotional factors?  □ Yes  □ No

If yes, please mark any known psychological conditions that affect this patient’s pain:
□ Depression  □ Anxiety  □ Somatoform disorder  □ Personality disorder
□ Other: __________________________________________________________________________________

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: ______________________________________________________
__________________________________________________________________________________________
__________________________________________________________________________________________

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 ☐ sit quietly 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?

<table>
<thead>
<tr>
<th>How many pounds</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Less than 10 lbs.</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>10 lbs.</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>20 lbs.</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>50 lbs.</td>
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<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

How often can your patient perform the following activities?

<table>
<thead>
<tr>
<th>How often</th>
<th>Never</th>
<th>Rarely</th>
<th>Occasionally</th>
<th>Frequently</th>
</tr>
</thead>
<tbody>
<tr>
<td>Twist</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Stoop (bend)</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Crouch</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Climb ladders</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Climb stairs</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
</tbody>
</table>

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 _____%

Do the patient’s impairments require limited exposure to changes in the environment?

<table>
<thead>
<tr>
<th>Extreme Cold</th>
<th>Never</th>
<th>Rarely</th>
<th>Avoid Prolonged Exposure</th>
<th>Avoid Moderate Exposure</th>
<th>Avoid All Exposure</th>
</tr>
</thead>
<tbody>
<tr>
<td>Extreme Heat</td>
<td>☐</td>
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<td>☐</td>
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</tr>
<tr>
<td>Fumes, odors, dusts, gasses</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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</tr>
<tr>
<td>Humidity</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
</tr>
<tr>
<td>Noise</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<td>☐</td>
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<tr>
<td>Heights</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Hazardous machinery</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Water</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>Others: _________________________________________</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
<td>☐</td>
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<tr>
<td>________________________________________________</td>
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</tr>
</tbody>
</table>
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