**RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE FOR CARPAL TUNNEL, ARTHRITIC, AND/OR NEUROPATHIC CONDITIONS OF THE UPPER EXTREMITY**

Re: \_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_(Name of Patient) \_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_(Social Security No.)

Please answer the following questions concerning your patient's impairments.  ***Please attach all relevant treatment notes, radiologist reports, laboratory and test results which reflect any of the diagnoses mentioned above.***

1. Nature, frequency and length of contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. Does your patient have either Carpal Tunnel Syndrome or a neurological or physical problem that affects his or her upper extremity?   \_\_\_ Yes   \_\_\_ No

3. Primary and secondary diagnoses: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. Prognosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. Have your patient's impairments lasted or can they be expected to last at least 12 months?  \_\_\_ Yes \_\_\_ No

6. Identify the *clinical findings*, laboratory and test results which show your patient's medical impairments:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

7. Please Identify all of your patient's symptoms (check and circle where appropriate):

\_\_ Pain in the hand/s, \_\_ Pain in the finger/s, \_\_ Pain in the wrist/s, \_\_ Numbness or tingling in the hands, fingers or wrists, \_\_ Stiffness in the hand/s, finger/s, wrist/s or elbows, \_\_ Muscle weakness in the hands and/or fingers, wrist/s,

\_\_ Swelling in the hand/s and/or finger/s, wrist/s, or elbow/s \_\_ Muscle weakness in the elbow or shoulder, \_\_ Pain in the elbow and/or shoulder, \_\_ Pain at Night, \_\_ loss of function in the use of the patient’s hand/s, finger/s, wrist/s, elbow/s or shoulder/s? \_\_\_ Pain is increased by repetitive use \_\_ A need to use a splint or hand, wrist or elbow supportive brace or device? \_\_ Raynaud's Phenomenon present \_\_ Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

8. Does the patient suffer from any other physical affliction (Rheumatoid or Osteoarthritis, for example) that may cause an aggravation of his/her underlying condition mentioned above? \_\_ Yes \_\_ No

If Yes, please describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

9. Does the patient’s condition cause a loss or limitation of manual dexterity? \_\_ Yes \_\_ No

10. Does the patient’s condition cause a loss or limitation of grip strength? \_\_ Yes \_\_ No

11. Does the patient’s condition cause a loss or limitation of pinch strength between the thumb & any of his/her fingers? \_\_ Yes \_\_ No

12. Does the claimant’s condition affect his or her ability to finger, feel, and/or do fine manipulation? \_\_ Yes \_\_ No

13. Does the claimant’s condition affect his or her ability to feel the size, shape, temperature or texture of an object by the fingertips? \_\_ Yes \_\_ No

14. Does the patient’s condition cause a loss of feeling in the fingers, sometimes increasing to complete numbness?

\_\_ Yes \_\_ No

15. Does the patient suffer from pain at night in the hand, fingers, writs, elbow or shoulder that causes him/her to have nonrestorative sleep? \_\_ Yes \_\_ No

16. Is your patient a malingerer?    \_\_\_ Yes \_\_\_ No

17. If your patient has pain:

a. Please identify the location of pain including, where appropriate, an indication of right or left side or bilateral areas affected:

**RIGHT   LEFT          BILATERAL**

**Hand/s \_\_\_ \_\_\_ \_\_\_**

**Finger/s \_\_\_ \_\_\_ \_\_\_**

**Arm/s \_\_\_ \_\_\_ \_\_\_**

**Shoulder/s \_\_\_ \_\_\_ \_\_\_**

\_\_  Lumbosacral spin \_\_

\_\_  Cervical spi\_\_  Shoulderb. 18. Please describe the nature, frequency, and severity of your patient's pain:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. Please Identify any factors that precipitate pain:

\_\_ Fatigue \_\_Changing weather \_\_ Movement/Overuse    \_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_ Cold \_\_Stress \_\_ Hormonal Changes \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

19. Does your patient have *significant limitations* in doing *repetitive* activities with his/her finger/s, hand/s, wrist/s, arm/s, elbow/s or shoulder/s?    \_\_ Yes \_\_ No

20. In competitive work, on the average, how many minutes per hour would you reasonably expect the patient to be off task due to the pain or limitations imposed upon him/her due to his or her diagnosed condition/s above?

\_\_\_\_\_\_\_ **Minutes per hour**

***For this and other questions on this form, “rarely@ means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.***

**a. The Patient may lift, push, pull, and carry in full time work within the following limitations:**

**Never** **Rarely     Occasionally       Frequently Never**

Less than 5 lbs. \_\_\_ \_\_\_ \_\_\_ \_\_\_

Less than 10 lbs. \_\_\_ \_\_\_ \_\_\_ \_\_\_

10 lbs – 20 lbs.   \_\_\_ \_\_\_ \_\_\_ \_\_\_

20 lbs. or more \_\_\_ \_\_\_ \_\_\_ \_\_\_

Overhead Lift \_\_\_ \_\_\_ \_\_\_ \_\_\_

**If yes**, please indicate the percentage of time during an 8-hour workday, in a competitive job, that you would recommend the patient to use his/her hands/fingers/arms/elbows and shoulders for the following repetitive activities:

**Rarely     Occasionally       Frequently** **Never**

**FINGERS** Right Hand \_\_\_ \_\_\_ \_\_\_ \_\_\_

(doing tasks like writing with a pen and/or typing with a keyboard)

**FINGERS** Left Hand \_\_\_ \_\_\_ \_\_\_ \_\_\_

**RIGHT HAND** \_\_\_ \_\_\_ \_\_\_

(doing fine manipulative tasks like reaching, grasping, turning, touching and twisting objects)

**LEFT HAND** \_\_\_ \_\_\_ \_\_\_ \_\_\_

**RIGHT ARM**

(pushing, pulling and reaching to shoulder level)

**LEFT ARM** \_\_\_ \_\_\_ \_\_\_ \_\_\_

**RIGHT SHOULDER** \_\_\_ \_\_\_ \_\_\_ \_\_\_

(pushing, pulling and reaching at shoulder level and above)

**LEFT SHOULDER** \_\_\_ \_\_\_ \_\_\_ \_\_\_

Please explain the cause for the above limitations. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

21. How often during a typical workday would the patient’s experience of pain or other symptoms associated with his/her upper extremity be severe enough to interfere with **attention and concentration** needed to perform even simple, routine, repetitive work tasks? **\_\_ Never  \_\_ Rarely \_\_ Occasionally \_\_ Frequently \_\_ Constantly**

22. To what degree can the patient tolerate normal work stress? \_\_ Incapable of even “low stress” jobs, \_\_Capable of low stress jobs not requiring a consistent or steady pace \_\_Moderate stress is okay \_\_Capable of high stress work

23. Please identify any medications and/or their side effects that may have implications for working, (e.g., dizziness, drowsiness, stomach upset, etc.) that would interfere with patient’s ability to maintain attention, concentration or focus for 8 hrs of an 8 hr work day.:  \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

24. As a result of your patient's impairments, estimate your patient's functional limitations if your patient were placed in a *competitive work situation.*

a. Will the patient sometimes need to unscheduled breaks for the joints of the upper extremity?    \_\_\_ Yes \_\_\_ No

**If yes:**  1)  how *often* do you think this will happen?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2)  how *long* (on average) will your patient have to rest before returning to work? \_\_\_\_\_\_\_\_\_\_\_\_\_

25. Are patient’s impairments likely to produce “good days” and “bad days”? \_\_ Yes   \_\_No

**If yes**, please estimate, on the average, how many days per month your patient is likely to be late to, leave early and/or 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

26. Are your patient's impairments *reasonably consistent* with his/her physical symptoms on clinical presentation, objective testing and the functional limitations described in this evaluation? \_\_\_ Yes    \_\_\_ No

**If no**, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

27. Please describe any other limitations that would affect your patient's ability to work at a regular job on an uninterrupted and sustained basis that you would deem necessary. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**28. What is the earliest date** the symptoms and limitations herein apply to the patient? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (Earliest date applied)

*\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

***Physician’s Signature Date form completed***

***Physician’s Printed/Typed Name****: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

*Physician’s Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

**(Or attach business card)** *\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_*

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Return form to:  Mike Murburg, PA**

**Disabilityattorney.net**

**15501 N. Florida Ave**

**Tampa, FL 33613**

**Tel: 813-264-5363**

**Fax: 813-961-6011**

**Copyright: Norman Michael Murburg, Jr**