

BRAD THOMAS DISABILITY, PLLC



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Physical Functional Capacity Report

Patient: _____

SS #: _____

Date of Birth: _____

Dear Provider - Please respond to the following questions regarding your patient's disability. This will be used as medical evidence for a Social Security disability claim.

Please be specific with regards to your patient's medical ailments and how they affect his or her daily activities both at work and at home:

A. BACKGROUND

1. With regards to your contact with the patient, please describe the frequency and purpose:

2. Please describe the patient's symptoms as completely as possible:

B. EXERTIONAL LIMITATIONS

1. Occasionally lift and/or carry (including upward pulling)

- less than 10 pounds
- 10 pounds
- 20 pounds
- 50 pounds
- 100 pounds or more

2. Frequently lift and/or carry (including upward pulling)

- less than 10 pounds
- 10 pounds
- 20 pounds
- 50 pounds
- 100 pounds or more

3. Stand and/or walk (with normal breaks) for a total of

- less than 2 hours in an 8-hour workday
- about 4 hours in an 8-hour workday
- at least 6 hours in an 8-hour workday

4. Sit (with normal breaks) for a total of

- less than 2 hours in an 8-hour workday
- about 4 hours in an 8-hour workday
- at least 6 hours in an 8-hour workday

5. Push and/or pull (including operation of hand and/or foot controls)

- unlimited, other than as shown for lift and/or carry.
- limited upper extremities (describe nature and degree)
- limited in upper extremities (describe nature and degree)

C. MANIPULATIVE LIMITATIONS

	Frequently	Occasionally	Less than Occasionally	Never
1. Reaching all directions (also overhead) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Handling (gross manipulation) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Fingering (fine manipulation) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling (skin receptors) -----	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

D. OTHER LIMITATIONS

1. Does your patient use any of the following? (*Check all that apply*)

- | | | |
|--|--|---|
| <input type="checkbox"/> Crutches | <input type="checkbox"/> Cane | <input type="checkbox"/> Hearing Aid |
| <input type="checkbox"/> Walker | <input type="checkbox"/> Brace/Split | <input type="checkbox"/> Glasses/Contact Lenses |
| <input type="checkbox"/> Wheelchair | <input type="checkbox"/> Artificial Limb | <input type="checkbox"/> Artificial Voice Box |
| <input type="checkbox"/> Others (please specify) _____ | | |

2. Which of these devices is there a medical need for? _____

3. Would your patient need to use both hands to use this device? _____

4. When does the patient need to use the device? _____

5. Does your patient need to elevate their legs due to their medical conditions? Yes/No

5a. If yes, many times a day should they elevate their legs, and for how long?

5b. How high do they need to elevate their legs? To waist level _____ Above heart level _____
Other _____

6. In an average month how frequently would you expect your patient to have unexpected absences from work?

- Never Once a month Twice a month Three or more

7. What percentage of the workday would you expect your patient to be off task in a work setting to distractions caused by their conditions or impairments?

- 0% 5% 10% 15% 20% or more

8. Is your patient a malingerer?

- Yes No

Date Report Completed: _____

Signature of Physician: _____

Physician Name: _____

Address: _____

Telephone: _____

Speciality: _____