

**PHYSICAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT**

CLAIMANT:		SOCIAL SECURITY NUMBER	
NUMBERHOLDER (IF CDB OR DWB CLAIM)			
PRIMARY DIAGNOSIS:	RFC ASSESSMENT IS FOR: <input type="checkbox"/> Date 12 Months After Onset		
SECONDARY DIAGNOSIS:	<input type="checkbox"/> Current Evaluation	(Date)	_____
OTHER ALLEGED IMPAIRMENTS:	<input type="checkbox"/> Date Last Insured	(Date)	_____
OTHER ALLEGED IMPAIRMENTS CONTINUED:	<input type="checkbox"/> Other (Specify): _____		

**1. LIMITATIONS:**

**For Each Section A - F**

Base your conclusions on **all evidence** in file (clinical and laboratory findings, symptoms, observations, lay evidence, reports of daily activities, etc.).

Check the blocks which reflect your **reasoned judgment**.

Describe how the **evidence substantiates your conclusions** (Cite specific clinical and laboratory findings, observations, lay evidence, etc.).

Ensure that you have:

- Requested appropriate medical opinions (DI 22505.000ff. and DI 22510.000ff.) and that you have given appropriate **consideration to medical opinions** (See Section 3.).
- Considered and responded to **any alleged limitations imposed by symptoms** (pain, fatigue, etc.) attributable, in your judgment, to a medically determinable impairment. Discuss your assessment of symptom-related limitations in the explanation for your conclusions in A - F below (See also Section 2.).
- Responded to all allegations of physical limitations or factors which can cause physical limitations.

**Frequently** means occurring one-third to two-thirds of an 8-hour workday (cumulative, not continuous).

**Occasionally** means occurring from very little up to one-third of an 8-hour workday (cumulative, not continuous).

## A. EXERTIONAL LIMITATIONS

None established. (Proceed to section B.)

1. **Occasionally** lift and/or carry (including upward pulling) (maximum) - when less than one-third of the time or less than 10 pounds, explain the amount (time/pounds) in item 6.

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

2. **Frequently** lift and/or carry (including upward pulling) (maximum) - when less than two-thirds of the time or less than 10 pounds, explain the amount (time/pounds) in item 6.

- less than 10 pounds
- 10 pounds
- 25 pounds
- 50 pounds or more

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

- less than 2 hours in an 8-hour workday
- at least 2 hours in an 8-hour workday
- about 6 hours in an 8-hour workday
- medically required hand-held assistive device is necessary for ambulation

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

- less than about 6 hours in an 8-hour workday
- about 6 hours in an 8-hour workday
- must periodically alternate sitting and standing to relieve pain or discomfort. (If checked, explain in item 6.)

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

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

6. Explain how and why the evidence supports your conclusions in items 1 through 5.  
Cite the specific facts upon which your conclusions are based.

**B. POSTURAL LIMITATIONS**

None established. (Proceed to section C.)

	Frequently	Occasionally	Never
1. Climbing - ramp/stairs _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
- ladder/rope/scaffolds _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
2. Balancing _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
3. Stooping _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
4. Kneeling _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
5. Crouching _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
6. Crawling _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. When less than two-thirds of the time for frequently or less than one-third for occasionally, fully describe and explain. Also, explain how and why the evidence supports your conclusions in items 1 through 6. Cite the specific facts upon which your conclusions are based.

**C. MANIPULATIVE LIMITATIONS**

None established. (Proceed to section D.)

	LIMITED	UNLIMITED
1. Reaching all directions (including overhead) _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Handling (gross manipulation) _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Fingering (fine manipulation) _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Feeling (skin receptors) _____	<input type="checkbox"/>	<input type="checkbox"/>

5. Describe how the activities checked "limited" are impaired. Also, explain how and why the evidence supports your conclusions in items 1 through 4. Cite the specific facts upon which your conclusions are based.

D. VISUAL LIMITATIONS

None established. (Proceed to section E.)

	LIMITED	UNLIMITED
1. Near acuity _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Far acuity _____	<input type="checkbox"/>	<input type="checkbox"/>
3. Depth perception _____	<input type="checkbox"/>	<input type="checkbox"/>
4. Accommodation _____	<input type="checkbox"/>	<input type="checkbox"/>
5. Color Vision _____	<input type="checkbox"/>	<input type="checkbox"/>
6. Field of vision _____	<input type="checkbox"/>	<input type="checkbox"/>

7. Describe how the faculties checked "limited" are impaired. Also, explain how and why the evidence supports your conclusions in items 1 through 6. Cite the specific facts upon which your conclusions are based.

E. COMMUNICATIVE LIMITATIONS

None established. (Proceed to section F.)

	LIMITED	UNLIMITED
1. Hearing _____	<input type="checkbox"/>	<input type="checkbox"/>
2. Speaking _____	<input type="checkbox"/>	<input type="checkbox"/>

3. Describe how the faculties checked "limited" are impaired. Also, explain how and why the evidence supports your conclusions in items 1 and 2. Cite the specific facts upon which your conclusions are based.

F. ENVIRONMENTAL LIMITATIONS

None established. (Proceed to Section 2.)

UNLIMITED

AVOID  
CONCENTRATED  
EXPOSURE

AVOID  
MODERATE  
EXPOSURE

AVOID ALL  
EXPOSURE

- |   |                          |                          |                          |                          |
|---|--------------------------|--------------------------|--------------------------|--------------------------|
| 1. Extreme cold _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 2. Extreme heat _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 3. Wetness _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 4. Humidity _____   | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 5. Noise _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 6. Vibration _____  | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 7. Fumes, odors, _____<br>dust, gases,<br>poor ventilation,<br>etc. | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |
| 8. Hazards _____<br>(machinery, heights, etc.)                      | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> | <input type="checkbox"/> |

9. Describe how these environmental factors impair activities and identify hazards to be avoided. Also, explain how and why the evidence supports your conclusions in items 1 through 8. Cite the specific facts upon which your conclusions are based.

**2. SYMPTOMS:**

For symptoms alleged by the claimant to produce physical limitations, and for which the following have not previously been addressed in Section 1, discuss whether:

- A. The symptom(s) is attributable, in your judgment, to a medically determinable impairment.
- B. The severity or duration of the symptom(s), in your judgment, is disproportionate to the expected severity or expected duration on the basis of the claimant's medically determinable impairment(s).
- C. The severity of the symptom(s) and its alleged effect on function is consistent, in your judgment, with the total medical and nonmedical evidence, including statements by the claimant and others, observations regarding activities of daily living, and alterations of usual behavior or habits.

**3. MEDICAL OPINION(S):**

A. Is a medical opinion(s) in file?

Yes

No (Includes situations in which there was no medical source or when the medical source(s) did not provide a medical opinion).

B. If yes, is the medical opinion(s) significantly different from your findings?

Yes

No

C. If yes, explain why the medical opinion(s) is not consistent with or supported by the evidence in file. Cite the medical source's name and the medical opinion date.

**4. ADDITIONAL COMMENTS:**

**5. SIGNATURE:**

A. Signatory's Role

Medical Consultant (**MC**)

OR

Single Decisionmaker (**SDM**)

B. MC's Statement

The MC does **not** check this block when the MC's assessment is preliminary, advisory or partial.

THESE FINDINGS COMPLETE THE MEDICAL PORTION OF THE DISABILITY DETERMINATION.

SIGNATURE:

MEDICAL CONSULTANT'S CODE:

DATE: