PHYSICAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

CLAIMANT:	SOCIAL SECURITY NUMBER
NUMBERHOLDER (IF CDB OR DWB CLAIM)	

PRIMARY DIAGNOSIS:	RFC ASSESSMENT IS FOR: ☐ Date 12 Months After Onset (Date) _____
SECONDARY DIAGNOSIS:	☐ Current Evaluation ☐ Date Last Insured (Date) _____
OTHER ALLEGED IMPAIRMENTS:	☐ Other (Specify): _____

OTHER ALLEGED IMPAIRMENTS CONTINUED:

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	☐	☐	☐
- ladder/rope/scaffolds	☐	☐	☐
2. Balancing	☐	☐	☐
3. Stooping	☐	☐	☐
4. Kneeling	☐	☐	☐
5. Crouching	☐	☐	☐
6. Crawling	☐	☐	☐

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)	☐	☐
2. Handling (gross manipulation)	☐	☐
3. Fingering (fine manipulation)	☐	☐
4. Feeling (skin receptors)	☐	☐

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	☐	☐
2. Far acuity	☐	☐
3. Depth perception	☐	☐
4. Accommodation	☐	☐
5. Color Vision	☐	☐
6. Field of vision	☐	☐

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	☐	☐
2. Speaking	☐	☐

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	☐	☐	☐	☐
2. Extreme heat	☐	☐	☐	☐
3. Wetness	☐	☐	☐	☐
4. Humidity	☐	☐	☐	☐
5. Noise	☐	☐	☐	☐
6. Vibration	☐	☐	☐	☐
7. Fumes, odors, dust, gases, poor ventilation, etc.	☐	☐	☐	☐
8. Hazards (machinery, heights, etc.)	☐	☐	☐	☐

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: