PHYSICAL ABILITY ASSESSMENT

We are evaluating your patient's disability claim in order to determine functional impairment Please check the boxes corresponding to the patient's level of physical functioning. **Please substantiate your findings with medical documentation. (Failure to provide the requested reports/data may result in delay in claim determinations).**

Patient Name_____ Date of Birth_____
Diagnosis(es)/ICD-9 Code_____

Throughout **an 8-hour workday, the patient can tolerate, *with positional changes and meal breaks*, the following activities for the specified durations:**

		Not applicable to diagnosis(es)	Continuously (67-100%) (5.5 + hrs)	Frequently (34-66%) (2.5 - 5.5 hrs)	Occasionally (1-33%) (<2.5 hrs)	Check if supported by objective findings
Sitting:						
Standing:						
Walking:						
Reaching:	Overhead					
	Desk Level					
	Below Waist					
Fine Manipulation:	Right:					
	Left:					
Simple Grasp:	Right:					
	Left:					
Firm Grasp:	Right:					
	Left:					
Lifting:	10 lbs.					
	11-20 lbs.					
	21-50 lbs.					
	51-100 lbs.					
	100+ lbs.					
Carrying:	10 lbs.					
	11-20 lbs.					
	21-50 lbs.					
	51-100 lbs					
.						
	100+ lbs.					

.	**Not applicable to diagnosis(es)**	**Continuously (67-100%) (5.5 + hrs)**	**Frequently (34-66%) (2.5 - 5.5 hrs)**	**Occasionally (1-33%) (<2.5 hrs)**	**Check if supported by objective findings**
Pushing: (Max. Wt.:_____)					
Pulling: (Max. Wt.:_____)					
Climbing: Regular Stairs					
Regular Ladders					
Balancing:					
Stooping:					
Kneeling:					
Crouching:					
Crawling:					
Seeing:					
Hearing:					
Smell/Taste:					
Environmental Conditions: Exposure to extremes in heat					
Exposure to extremes in cold					
Exposure to wet / humid conditions					
Exposure to vibration					
Exposure to odors / fumes / particles					
Can work around machinery					
Ability to work extended shifts/ overtime:					
Use lower extremities for foot controls:					

Please use this space to elaborate on ANY of the above categories:

_____

_____

_____

_____

Name: _____ **Signature:** _____

Medical Specialty: _____ Date: _____

Address: _____ Phone: _____

Federal ID tax number:_____

Please include any objective test or narrative if available.
Thank you for your time.

Please return this form in the enclosed addressed envelope.