

Chiari Malformation and Syringomyelia Residual Functional Capacity Questionnaire

Re: _____ (Name of Patient)
 _____ (Social Security No.)

1. Listing 11.19 Syringomyelia Does your patient have syringomyelia with:

- A. Significant bulbar signs; or
- B. Significant and persistent disorganization of motor function in two extremities, resulting in sustained disturbance of gross and dexterous movements, or gait and station.

Yes No

2. Listing 1.04 Disorders of the spine Does your patient have:

- | | | |
|-----------------------------------|----------------------------|--|
| ___ Scoliosis | ___ Spinal Stenosis | ___ Cranial-Vertebral Junction Instability |
| ___ Osteoarthritis | ___ Vertebral Fracture | ___ Herniated Nucleus Pulposus |
| ___ Facet Arthritis | ___ Arachnoiditis | ___ Degenerative Disc Disease |
| ___ Spina Bifida | ___ Chiari Malformation(s) | ___ Klippel-Feil Syndrome |
| ___ other bony abnormality: _____ | | |

With one or more of the following:

- A. Evidence of nerve root compression characterized by neuro-anatomic distribution of pain, limitation of motion of the spine, motor loss (atrophy with associated muscle weakness or muscle weakness) accompanied by sensory or reflex loss and, if there is involvement of the lower back, positive straight-leg raising test (sitting and supine); or
- B. Spinal arachnoiditis, confirmed by an operative note or pathology report of tissue biopsy, or by appropriate medically acceptable imaging, manifested by severe burning or painful dysesthesia, resulting in the need for changes in position or posture more than once every 2 hours; or
- C. Lumbar spinal stenosis resulting in pseudoclaudication, established by findings on appropriate medically acceptable imaging, manifested by chronic nonradicular pain and weakness, and resulting in inability to ambulate without the use of a walker or two canes?

Yes No

3. If yes to items 1 or 2, identify the physical examination findings and test results that are consistent with the existence of this disorder:

4. Please identify your patient's accompanying conditions, if any:

Migraine Headaches	Hydromyelia
Reflex Sympathetic Dystrophy	Arachnoid Cyst and/or Lipoma
Tachycardia, P.O.T.S., or Orthostatic Hypotension	Cataplexy (drop attacks)
Pseudo Meningocele	Hydrocephalus
Tethered Cord	Neck and/or Back Spasms
Chronic Fatigue Syndrome	Fibromyalgia and/or TMJ
Muscle weakness	Tremors
Dysphasia	Irritable Bowel Syndrome
Gastroesophageal Reflux Disease	Nausea and/or Vomiting
Vertigo	Tinnitus
Meniere's Disease	Chronic Sinusitis
Raynaud's Disease or Phenomenon	Carpal Tunnel Syndrome
Hyper or Hypothyroidism	Hypoglycemia
Depression	Anxiety and/or Panic attacks
Narcolepsy	Insomnia
Sleep Apnea	(Other)

5. Does your patient have significant limitation of motion (LOM) in the cervical or dorsolumbar spine?

Yes No

If yes, indicate LOM with the following movements:

Cervical	Flexion _____	Lateral bending - right _____
	Extension _____	Lateral bending - left _____
Dorsolumbar	Flexion _____	Lateral bending - right _____
	Extension _____	Lateral bending - left _____

6. *Sitting* Straight-leg Raising test: ___ positive ___ negative *Supine* Straight-leg Raising test: ___ positive ___ negative

7. What is your patient's prognosis? _____

8. Describe the treatment and response including any side effects of medication which may have implications for working, e.g., drowsiness, dizziness, nausea, etc.:

9. Is your patient a malingerer? Yes No

10. Are your patient's impairments (physical impairments plus any mental impairments) *reasonably consistent* with the symptoms and functional limitations described in this evaluation?

Yes No

If no, please explain:

11. How often is your patient's experience of pain, fatigue or other symptoms severe enough to interfere with attention and concentration?

Never Seldom Often Frequently Constantly

12. To what degree is your patient limited in the ability to deal with work stress?

No limitation Slight limitation Moderate limitation
 Marked limitation Severe limitation

13. 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. How many city blocks can your patient walk without rest? _____

b. Please circle the number of hours and/or minutes that your patient can *continuously* sit and stand *at one time*:

Sit:

Stand:

0 5 10 15 20 30 45 1 2 More than 2
Minutes Hours

0 5 10 15 20 30 45 1 2 More than 2
Minutes Hours

c. Please indicate how long your patient can sit and stand/walk *total in an 8 hour working day* (with normal breaks):

Sit	Stand/walk	
___	___	less than 2 hours
___	___	about 2 hours
___	___	about 4 hours
___	___	at least 6 hours

d. Does your patient need to include periods of walking around during an 8 hour working day?

Yes No

1. If yes, approximately how *often* must your patient walk?

1 5 10 15 20 30 45 60 90
Minutes

2. How long must your patient walk each time?

1 2 3 4 5 6 7 8 9 10 11 12 13 14 15
Minutes

e. Does your patient need a job which permits shifting positions *at will* from sitting, standing or walking?

Yes No

f. Will your patient sometimes need to take unscheduled breaks during an 8 hour working day?

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? _____

g. With prolonged sitting, should your patient's leg(s) be elevated?

Yes No

If yes, (1) how high should the leg(s) be elevated? _____

(2) if your patient had a sedentary job, what percentage of time during an 8 hour working day should the leg(s) be elevated? _____%

h. While engaging in occasional standing/walking, must your patient use a cane, walker, chair, scooter, or other assistive device?

Yes No

i. How many pounds can your patient lift and carry in a competitive work situation?

	Never	Occasionally	Frequently
less than 10 lbs.	_____	_____	_____
10 lbs.	_____	_____	_____
20 lbs.	_____	_____	_____
50 lbs.	_____	_____	_____

In an average 8 hour working day, "occasionally" means less than 1/3 of the working day; "frequently" means between 1/3 to 2/3 of the working day.

J. Please state the percentage of time during an 8 hour working day that your patient can bend and twist at the waist.

Bend _____% Twist _____%

k. Are your patient's impairments likely to produce "good days" and "bad days"?

Yes No

L. Does your patient have *significant limitations* in doing *repetitive* reaching, handling or fingering?

Yes No

If yes, please indicate the percentage of time during an 8 hour working day on a competitive job that your patient can use hands/fingers/arms for the following repetitive activities:

	HANDS: Grasp, Turn Twist Objects	FINGERS: Fine Manipulations	ARMS: Reaching (incl. Overhead)
Right:	%	%	%
Left:	%	%	%

m. On the average, how often do you anticipate that your patient's impairments or treatment would cause your patient to be absent from work?

- | | |
|---|--|
| <input type="checkbox"/> Never | <input type="checkbox"/> About twice a month |
| <input type="checkbox"/> Less than once a month | <input type="checkbox"/> About three times a month |
| <input type="checkbox"/> About once a month | <input type="checkbox"/> More than three times a month |

14. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or hazards, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

15. What is the earliest date that the description of symptoms *and limitations* in this questionnaire applies?

Date

Signature

Printed/Typed Name:

Address:
