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:

0 5 10 15 20 30 45 Minutes

1 2 More than 2 Hours

Stand:

0 5 10 15 20 30 45 Minutes

1 2 More than 2 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?

___ Never
___ Less than once a month
___ About once a month
___ About twice a month
___ About three times a month
___ 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: _____

_____