TAKE TO YOUR DOCTOR TO COMPLETE
PHYSICAL CAPACITIES EVALUATION

Name of claimant:____SSN:__________________________

*Important: Please complete the following items based on your clinical evaluation of the claimant and other testing results. Any item that you do not believe you can answer should be marked N/A (Not Answerable)

Note: In terms of an 8 hour workday, "occasionally" equals 1% to 33% of the day, "frequently" equals 34% to 66%, and "continuously" equals 67% to 100%.

I. IN AN 8-HR WORKDAY CLAIMANT CAN: (Circle full capacity for each activity)

TOTAL - **AT ONE TIME**

A) Sit	-	0	1/2	1	2	3	4	5	6	7	8 (hrs)
B) Stand	-	0	1/2	1	2	3	4	5	6	7	8 (hrs)
C) Walk	-	0	1/2	1	2	3	4	5	6	7	8 (hrs)

TOTAL - **DURING ENTIRE 8-HOUR WORK DAY**

A) Sit	-	0	1/2	1	2	3	4	5	6	7	8 (hrs)
B) Stand	-	0	1/2	1	2	3	4	5	6	7	8 (hrs)
C) Walk	-	0	1/2	1	2	3	4	5	6	7	8 (hrs)

II. Claimant can lift:

	Not at all	Occasionally	Frequently	Continuously
A) Up to 5 lbs.	___	___	___	___
B) 6-10 lbs.	___	___	___	___
C) 11-20 lbs.	___	___	___	___
D) 21-25 lbs.	___	___	___	___
E) 26-50 lbs.	___	___	___	___
F) 51-100 lbs.	___	___	___	___

III. Claimant can carry:

	Not at all	Occasionally	Frequently	Continuously
A) Up to 5 lbs.	___	___	___	___
B) 6-10 lbs.	___	___	___	___
C) 11-20 lbs.	___	___	___	___
D) 21-25 lbs.	___	___	___	___
E) 26-50 lbs.	___	___	___	___
F) 51-100 lbs.	___	___	___	___

IV. Claimant can use hands for repetitive action such as:

	Simple Grasping	Pushing & Pulling of Arm Controls	Fine Manipulation
A. Right	___Yes ___No	___Yes ___No	___Yes ___No
B. Left	___Yes ___No	___Yes ___No	___Yes ___No

V. Claimant can use feet for repetitive movements as in pushing of leg controls:

Right	Left	Both
___Yes ___No	___Yes ___No	___Yes ___No

VI. Claimant is able to:

	Not at all	Occasionally	Frequently	Continuously
A. Bend	___	___	___	___
B. Squat	___	___	___	___
C. Crawl	___	___	___	___
D. Climb	___	___	___	___
E. Reach	___	___	___	___
F. Stoop	___	___	___	___

VII. Restriction of activities involving:

	None	Mild	Moderate	Total
A. Unprotected heights	___	___	___	___
B. Being around moving machinery	___	___	___	___
C. Exposure to marked changes in temperatures & humidity	___	___	___	___
D. Driving automotive equipment	___	___	___	___
E. Exposure to dust, fumes & gases	___	___	___	___

VIII. Is the above named ADDITIONALLY limited in his/her activities by (pain, fatigue, dizziness, other) ___Yes ___No (Please specify__________________
____)

If ______________________________ is present, how does it affect claimant's ability to function?

None	Mild	Moderate	Moderately Severe	Severe
___	___	___	___	___

*Definitions of Rating Terms:
None: no impairment in this area
Mild: suspected impairment of slight importance which does not affect ability to function.
Moderate: an impairment which affects but does not preclude ability to function.
Moderately Severe: an impairment which seriously interferes with ability to function.
Severe: extreme impairment of ability to function

Can the above be reasonably expected to result from the diagnosed medically determinable impairment(s)?

___Yes ___No

Diagnoses:

Remarks on above or other functional limitations:

Signature

Date

Printed Name

Clinic or Facility Name