THE LAW OFFICES OF
Gregory K. Kornegay
ATTORNEY AT LAW

Telephone: (910) 763-5757 Toll Free: 1-866-579-5757 Fax: (910) 763-5677

Attached to this letter you will find a Physical Medical Questionnaire (*Physical Residual Functional Capacity Questionnaire*). Please have your doctor complete the form. You should return the form to us after you pick it up from your doctor. Please remember the following:

1. **The form should be *signed by a Medical Doctor (M.D.) – not a physician's assistant or nurse*.**
2. This form is very important to your case as it provides medical evidence in support of your disability.
3. We cannot force your doctor to complete the form for you.
4. We do not tell the doctor how to complete the form for you.
5. The questions on the form are to gather the doctor's best estimate as to your functional limitations.
6. **SEND THE COMPLETED FORM TO US AT:**

MAIL:
Gregory Kornegay
P.O. Box 900
Wilmington, N.C. 28402; or

FAX: (910) 763-5677; or

EMAIL: gkornegay@aol.com

Sincerely,

GREGORY K. KORNEGAY

PHYSICAL RESIDUAL FUNCTIONAL CAPACITY QUESTIONNAIRE

PATIENT'S NAME: ______________________________ D.O.B.: ____________

Please answer the following questions concerning your patient's impairments.

1. Nature, frequency and length of contact: ____________________________________

   ____

2. Diagnoses: ____

   ____

3. Prognosis: ____

4. List your patient's *symptoms*, including pain, dizziness, fatigue, etc.:

   ____

   ____

5. If your patient has pain, characterize the nature, location, frequency, precipitating factors, and severity of your patient's pain:

   ____

   ____

   ____

6. Identify the clinical findings and objective signs:

   ____

   ____

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

____

____

8. Have your patient's impairments lasted or can they be expected to last at least twelve months?
   Yes No

9. Is your patient a malingerer? Yes No

10. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations?
    Yes No

11. Identify any psychological conditions affecting your patient's physical condition:

    ( ) Depression
    ( ) Somatoform disorder
    ( ) Psychological factors affecting physical condition
    ( ) Anxiety
    ( ) Personality disorder
    ( ) Other: ____

12. Are your patient's impairments (physical impairments plus any emotional impairments) *reasonably consistent* with the symptoms and functional limitations described in this evaluation? Yes No

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

    ( ) Never ( ) Seldom ( ) Often ( ) Frequently ( ) Constantly

14. To what degree can your patient tolerate work stress?

    ( ) Incapable of even "low stress" jobs
    ( ) Capable of low stress jobs
    ( ) Moderate stress is okay
    ( ) Capable of high stress work

    Please explain the reasons for your conclusion: ______________________________

    ____

15. 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 or severe pain?

   ____

   b. Please circle the hours and/or minutes that your patient can sit *at one time*, e.g., before needing to get up, etc.

   Sit: 0 5 10 15 20 30 45
   Minutes

   1 2 More than 2
   Hours

   c. Please circle the hours and/or minutes that your patient can stand *at one time,* e.g., before needing to sit down, walk around, etc.

   Stand: 0 5 10 15 20 30 45
   Minutes

   1 2 More than 2
   Hours

   d. How long can your patient 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

   e. Does your patient need to include periods of walking around during an 8-hour working day? Yes No

   If yes, (1)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

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

Yes No

g. Will your patient sometimes need to take unscheduled breaks during an 8-hour working shift? Yes No

If yes, (1) How often do you think this will happen?

____

(2) On average, how long will your patient have to rest before returning to work? ____

h. 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? __________________________%

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

Yes No

For the next two questions, "rarely" means 1% to 5% of an 8-hour working day; "occasionally" means 6% to 33% of an 8-hour working day; "frequently" means 34% to 66% of an 8-hour working day.

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

	Never	**Rarely**	**Occasionally**	**Frequently**
Less than 10 lbs.	( )	( )	( )	( )
10 lbs.	( )	( )	( )	( )
20 lbs.	( )	( )	( )	( )
50 lbs.	( )	( )	( )	( )

k. How often can your patient perform the following activities?

	Never	**Rarely**	**Occasionally**	**Frequently**
Twist	( )	( )	( )	( )
Stoop (bend)	( )	( )	( )	( )
Crouch	( )	( )	( )	( )
Climb ladders	( )	( )	( )	( )
Climb stairs	( )	( )	( )	( )

l. Are your patient's impairments likely to produce "good days" and "bad days?"
Yes No

If yes, please estimate, on the average, how many days per month your patient is likely to be absent from work as a result of the impairments or treatment:

( ) Never
( ) About one day per month
( ) About two days per month
( ) About three days per month
( ) About four days per month
( ) More than four days per month

16. Please describe any other limitations (such as psychological limitations, limited vision, difficulty hearing, etc.) that would affect your patient's ability to work at a regular job on a sustained basis:

____

____

____

________________________ ________________________

Date ***Signature***

Printed/Typed Name: ________________________

Address: ________________________

____