

## **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
<b>Sitting:</b>					
<b>Standing:</b>					
<b>Walking:</b>					
<b>Reaching:</b> Overhead					
Desk Level					
Below Waist					
<b>Fine Manipulation:</b> Right:					
Left:					
<b>Simple Grasp:</b> Right:					
Left:					
<b>Firm Grasp:</b> Right:					
Left:					
<b>Lifting:</b> 10 lbs.					
11-20 lbs.					
21-50 lbs.					
51-100 lbs.					
100+ lbs.					
<b>Carrying:</b> 10 lbs.					
11-20 lbs.					
21-50 lbs.					
51-100 lbs.					
100+ lbs.					



	<b>Not applicable to diagnosis(es)</b>	<b>Continuously (67-100%) (5.5 + hrs)</b>	<b>Frequently (34-66%) (2.5 - 5.5 hrs)</b>	<b>Occasionally (1-33%) (&lt;2.5 hrs)</b>	<b>Check if supported by objective findings</b>
<b>Pushing:</b> (Max. Wt.:_____)					
<b>Pulling:</b> (Max. Wt.:_____)					
<b>Climbing:</b> Regular Stairs					
Regular Ladders					
<b>Balancing:</b>					
<b>Stooping:</b>					
<b>Kneeling:</b>					
<b>Crouching:</b>					
<b>Crawling:</b>					
<b>Seeing:</b>					
<b>Hearing:</b>					
<b>Smell/Taste:</b>					
<b>Environmental Conditions:</b>					
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					
<b>Ability to work extended shifts/ overtime:</b>					
<b>Use lower extremities for foot controls:</b>					

*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.**