MENTAL / COGNITIVE FUNCTIONAL CAPACITY ESTIMATE
BASED ON EXAM, TREATMENT HISTORY OR RELEVANT TESTING

Patient Name: _____ **Date of Birth:** _____

Assessment By: _____ **Specialty:** _____

PHYSICIAN/PRACTITIONER INSTRUCTIONS: *Please mark **X** on patient's ability to do the following activities:*

COGNITIVE AND MENTAL ABILITIES

INTERACTION WITH PUBLIC (8-hour day): ☐ Never ☐ ≤ 2% day ☐ > 2% to 1/3 day ☐ 1/3 to 2/3 day ☐ > 2/3 day

CONCENTRATION, TASK COMPLETION:
☐ Able to Complete Normal Workday and Work Week (full-time)
☐ Never ☐ ≤ 2% day ☐ > 2% to 1/3 day ☐ 1/3 to 2/3 day ☐ > 2/3 day

PACE OF WORKLOAD SET BY:
☐ Machines ☐ Equipment ☐ Software ☐ Numerical Performance
☐ Targets ☐ People ☐ Self-Paced ☐ Other External Source

PAUSE CONTROL: ☐ Requires Ability To Pause Work ☐ Recommend Ability To Pause Work

WORK SPEED: ☐ Generally Fast ☐ Average / Varying Work Pace ☐ Generally Slow

PEOPLE SKILLS: ☐ Basic People Skills ☐ More Than Basic People Skills

BASIC PROBLEM SOLVING:
☐ More Than Once Per Day
☐ Once Per Day
☐ Not Every Day, But At Least Once Per Week
☐ Not Every Week, But At Least Once Per Month
☐ Less Often Than Monthly, Including Never

SUPERVISING OTHERS: ☐ Able to Demonstrate, Review and Oversee Other's Work ☐ Not Recommended

SUPERVISOR WORK REVIEW
☐ Able to Perform Work in Supervisor's Presence ☐ Not Recommended
☐ More Than Once/Day ☐ Once Per Day ☐ ≥ Once Per Day

VERBAL INTERACTIONS, INTERNAL (COWORKERS AND SUPERVISORS):
☐ Never ☐ ≤ 2% day ☐ > 2% to 1/3 day ☐ 1/3 to 2/3 day ☐ > 2/3 day
☐ Less Than Once per Week ☐ At Least Once per Week
☐ At Least Once Per Day ☐ At Least Once Per Hour ☐ Every Few Minutes

VERBAL INTERACTIONS, EXTERNAL:
☐ Never ☐ ≤ 2% day ☐ > 2% to 1/3 day ☐ 1/3 to 2/3 day ☐ > 2/3 day
☐ Less Than Once per Week ☐ At Least Once per Week
☐ At Least Once Per Day ☐ At Least Once Per Hour ☐ Every Few Minutes

WORKING AROUND CROWDS: ☐ Able to Work in Crowds ☐ In Proximity to Crowds ☐ Not Recommended

BREAK SCHEDULE REQUIRED:
☐ Morning _____ minutes ☐ "Lunch" _____ minutes ☐ Afternoon _____ minutes
☐ Requires _____ Additional Breaks of _____ minutes each

ATTENDANCE RELIABILITY:
☐ May have difficulty arriving at work on time or leaving early _____ times/month
☐ May have absences of _____ times/month

WORK SCHEDULE VARIABILITY: ☐ Required ☐ Not Required

I, _____ [print full name of practitioner] hereby attest that the function-by-function assessment of abilities assessed above are supported by this source's objective findings or examination, treatment history and diagnostic results.

Signature: _____ **Date Completed:** _____