PHYSICAL 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:*

PHYSICAL REQUIREMENTS	Never	Seldom ≤ 2% day	Occasionally > 2% to 1/3 day	Frequently 1/3 to 2/3 day	Constantly > 2/3 day
STANDING TOTAL (in 8-HR DAY):	☐	☐	☐	☐	☐
SITTING TOTAL (in 8-HR DAY):	☐	☐	☐	☐	☐
SITTING / STANDING CHOICE:	☐ Alternating required or ☐ Alternating recommended every ____ per ___				
WALKING TOTAL (in 8-HR DAY):	☐	☐	☐	☐	☐
BENDING (LOW POSTURES):	☐	☐	☐	☐	☐
CLIMBING LADDERS, ROPES, SCAFFOLDS:	☐	☐	☐	☐	☐
CLIMBING RAMPS OR STAIRS:	☐	☐	☐	☐	☐
CRAWLING:	☐	☐	☐	☐	☐
CROUCHING:	☐	☐	☐	☐	☐
DRIVING:	☐	☐	☐	☐	☐
FINE MANIPULATION:	☐	☐	☐	☐	☐
	☐ One Arm/Hand Only ☐ Both Arms/Hands				
KEYBOARDING:	☐	☐	☐	☐	☐
FOOT OR LEG CONTROLS:	☐	☐	☐	☐	☐
	☐ One Foot/Leg Only ☐ Both Feet/Legs				
GROSS MANIPULATION:	☐	☐	☐	☐	☐
	☐ One Arm/Hand Only ☐ Both Arms/Hands				
HEARING:	☐	☐	☐	☐	☐
KNEELING:	☐	☐	☐	☐	☐
LIFTING OR CARRYING:					
No Weight:	☐	☐	☐	☐	☐
Negligible Weight ≤ 1 lb.:	☐	☐	☐	☐	☐
> 1 lb. ≤ 10 lbs.:	☐	☐	☐	☐	☐
> 10 lbs. ≤ 25 lbs.:	☐	☐	☐	☐	☐
> 25 lbs. ≤ 50 lbs.:	☐	☐	☐	☐	☐
> 50 lbs. ≤ 75 lbs.:	☐	☐	☐	☐	☐
> 75 lbs. ≤ 100 lbs.:	☐	☐	☐	☐	☐
> 100 lbs.:	☐	☐	☐	☐	☐
PUSHING/PULLING WITH ARMS OR HANDS:	☐	☐	☐	☐	☐
	☐ One Arm/Hand Only ☐ Both Arms/Hands				
PUSHING/PULLING WITH FEET OR LEGS:	☐	☐	☐	☐	☐
	☐ One Foot/Leg Only ☐ Both Feet/Legs				
REACHING AT OR BELOW SHOULDER:	☐	☐	☐	☐	☐
	☐ One Arm/Hand Only ☐ Both Arms/Hands				
REACHING OVERHEAD:	☐	☐	☐	☐	☐
	☐ One Arm/Hand Only ☐ Both Arms/Hands				

PHYSICAL REQUIREMENTS	Never	Seldom ≤ 2% day	Occasionally > 2% to 1/3 day	Frequently 1/3 to 2/3 day	Constantly > 2/3 day
SPEAKING:	☐	☐	☐	☐	☐
STOOPING:	☐	☐	☐	☐	☐
VISION – NEAR:	☐	☐	☐	☐	☐
VISION – FAR:	☐	☐	☐	☐	☐
VISION – PERIPHERAL:	☐	☐	☐	☐	☐

ENVIRONMENTAL CONDITIONS	Never	Seldom ≤ 2% day	Occasionally > 2% to 1/3 day	Frequently 1/3 to 2/3 day	Constantly > 2/3 day
EXTREME COLD:	☐	☐	☐	☐	☐
EXTREME HEAT:	☐	☐	☐	☐	☐
HAZARDOUS CONTAMINANTS:	☐	☐	☐	☐	☐
	☐ Fully Mitigated ☐ Not Utilizing PPE ☐ Utilizing PPE				
HEAVY VIBRATIONS:	☐	☐	☐	☐	☐
HEIGHTS:	☐	☐	☐	☐	☐
	☐ Exposure Fully Mitigated ☐ Not Utilizing PPE ☐ Utilizing PPE				
HUMIDITY:	☐	☐	☐	☐	☐
MOVING MECHANICAL PARTS PROXIMITY:	☐	☐	☐	☐	☐
	☐ In Proximity ☐ Fully Mitigated ☐ Using PPE ☐ Not Using PPE				
NOISE INTENSITY LEVEL:	☐ Quiet ☐ Moderate ☐ Loud ☐ Very Loud Noise ☐ Not Using PPE ☐ Using PPE				
OUTDOORS:	☐	☐	☐	☐	☐
WETNESS:	☐	☐	☐	☐	☐

GENERAL COMMENTS:

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:** _____