|  |  |
| --- | --- |
| **Patient Name:** |  |

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Frequency | Continuously | Frequently | Occasionally | Never | Remarks: |
| Hours/day | **6-8hrs.** | **3-6hrs.** | **Up to 3 hrs.** | **0hrs.** |  |
| Sit |  |  |  |  |  |
| Stand |  |  |  |  |  |
| Walk |  |  |  |  |  |
| Bend |  |  |  |  |  |
| Squat |  |  |  |  |  |
| Crawl |  |  |  |  |  |
| Climb (Describe) |  |  |  |  |  |
| Ascend/Descend Stairs |  |  |  |  |  |
| Reach Above Shoulders |  |  |  |  |  |
| Simple grasping – Right hand |  |  |  |  |  |
| Simple grasping – Left hand |  |  |  |  |  |
| Fine Manipulation-Right Hand |  |  |  |  |  |
| Fine Manipulation-Left Hand |  |  |  |  |  |
| Lift-Right Hand | | | | | |
| 10 lbs. |  |  |  |  |  |
| 11-25 lbs. |  |  |  |  |  |
| 26-50 lbs. |  |  |  |  |  |
| 51-100 lbs. |  |  |  |  |  |
| Lift-Left Hand | | | | | |
| 10 lbs. |  |  |  |  |  |
| 11-25 lbs. |  |  |  |  |  |
| 26-50 lbs. |  |  |  |  |  |
| 51-100 lbs. |  |  |  |  |  |
| Carry-Right Hand | | | | | |
| 10 lbs. |  |  |  |  |  |
| 11-25 lbs. |  |  |  |  |  |
| 26-50 lbs. |  |  |  |  |  |
| 51-100 lbs. |  |  |  |  |  |
| Carry-Left Hand | | | | | |
| 10 lbs. |  |  |  |  |  |
| 11-25 lbs. |  |  |  |  |  |
| 26-50 lbs. |  |  |  |  |  |
| 51-100 lbs. |  |  |  |  |  |
| Lift Above Shoulders | | | | | |
| 10 lbs. |  |  |  |  |  |
| 11-25 lbs. |  |  |  |  |  |
| 26-50 lbs. |  |  |  |  |  |
| 51-100 lbs. |  |  |  |  |  |
| Push & Pull – Right hand | | | | | |
| 10 lb. |  |  |  |  |  |
| 11-25 lbs. |  |  |  |  |  |
| Hours/day | **6-8hrs.** | **3-6hrs.** | **Up to 3 hrs.** | **0hrs.** | **Remarks:** |
| 26-50 lbs. |  |  |  |  |  |
| 51-100 lbs. |  |  |  |  |  |
| Push & Pull – Left hand | | | | | |
| 10lbs. |  |  |  |  |  |
| 11-25 lbs. |  |  |  |  |  |
| 26-50 lbs. |  |  |  |  |  |
| 51-100 lbs. |  |  |  |  |  |

1. **The patient can use feet for repetitive movements as in operating foot controls:**

Right:  Yes  No Left:  Yes  No

1. **Is the patient restricted by environmental factors such as dampness, heat or cold, height, exposure to dust, gases, fumes, etc.?**

Yes  No

**If yes, please describe:**

1. **Is the patient involved with treatment and/or medications that might affect ability to work?**

Yes  No

**If yes, please describe:**

1. **Can the patient operate a motor vehicle**?  Car  Truck **| For how many hours? \_\_\_\_\_\_\_\_**
2. **Has the patient reached maximum medical improvement?**  Yes  No

**If no, please indicate anticipated date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **Is the patient released from care?**  Yes  No

**If no, next schedule follow-up date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

1. **How many hours can the patient work? \_\_\_\_\_\_\_\_ hours per day \_\_\_\_ days per week.**

**Any additional restrictions, limitations, or remarks:**

|  |  |
| --- | --- |
| **Prepared By:** |  |
| **Signature:** |  |
| **Date:** |  |