

Functional Capacity Evaluation

NAME	SSN or WID	DATE OF INJURY	DATE OF BIRTH
------	------------	----------------	---------------

Client works on average of 8 10 or 12 hours per day (check one)

1. In a work day, client can (check number of hours full capacity for each activity).

- | | | | | | | | | | | | | |
|----------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|----------------------------|-----------------------------|-----------------------------|-----------------------------|
| a. Sit | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 | <input type="checkbox"/> 11 | <input type="checkbox"/> 12 |
| b. Stand | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 | <input type="checkbox"/> 11 | <input type="checkbox"/> 12 |
| c. Walk | <input type="checkbox"/> 1 | <input type="checkbox"/> 2 | <input type="checkbox"/> 3 | <input type="checkbox"/> 4 | <input type="checkbox"/> 5 | <input type="checkbox"/> 6 | <input type="checkbox"/> 7 | <input type="checkbox"/> 8 | <input type="checkbox"/> 9 | <input type="checkbox"/> 10 | <input type="checkbox"/> 11 | <input type="checkbox"/> 12 |

Comments: (If appropriate, note frequency per hour or day)

NOTE: For a full regular work day "Occasionally" equals 1% to 33%, "Frequently" equals 34% to 66%, "Continuously" equals 67% to 100%

2. Client is able to: (check one)	Not at All	Occasionally	Frequently	Continuously
a. Twist	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Bend/Stoop (lumbar)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Cervical Bend	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
d. Squat	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
e. Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
f. Climb Ladders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
g. Climb Stairs	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
h. Reach Above Shoulder Level	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
i. Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
j. Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
k. Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
l. Walk on Uneven Ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
m. Work Above Ground	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
n. Push/Pull	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
o. Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

3. Client can carry (lbs.)	Seldom	Occasionally	Frequently	Continuously
_____	_____	_____	_____	_____

4. Client can lift (lbs.):	Seldom	Occasionally	Frequently	Continuously
a. Floor to Waist	_____	_____	_____	_____
b. Waist to Shoulder Level	_____	_____	_____	_____
c. Shoulder to Overhead	_____	_____	_____	_____
d. Waist to Waist	_____	_____	_____	_____

5. Client can use hands for frequent action such as:	Simple Grasping	Firm Grasping	Fine Manipulating
a. Right	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No
b. Left	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No

6. Client can use head and neck:	Not at All	Occasionally	Frequently	Continuously
a. Static position	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
b. Flexing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
c. Rotating	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

7. Restriction of Activities Required by Physical Impairment

<input type="checkbox"/> extreme cold	<input type="checkbox"/> extreme heat	<input type="checkbox"/> wet or humid	<input type="checkbox"/> slippery floors
<input type="checkbox"/> vibration	<input type="checkbox"/> near moving equipment	<input type="checkbox"/> drive auto/equipment	<input type="checkbox"/> other: _____

8. Comments/Recommendations

SIGNATURE OF THERAPIST	DATE
SIGNATURE OF PHYSICIAN	DATE