Reset

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	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	☐ 11	☐ 12
b. Stand	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	☐ 11	☐ 12
c. Walk	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	☐ 9	☐ 10	☐ 11	☐ 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	☐	☐	☐	☐
b. Bend/Stoop (lumbar)	☐	☐	☐	☐
c. Cervical Bend	☐	☐	☐	☐
d. Squat	☐	☐	☐	☐
e. Crawl	☐	☐	☐	☐
f. Climb Ladders	☐	☐	☐	☐
g. Climb Stairs	☐	☐	☐	☐
h. Reach Above Shoulder Level	☐	☐	☐	☐
i. Crouch	☐	☐	☐	☐
j. Kneel	☐	☐	☐	☐
k. Balance	☐	☐	☐	☐
l. Walk on Uneven Ground	☐	☐	☐	☐
m. Work Above Ground	☐	☐	☐	☐
n. Push/Pull	☐	☐	☐	☐
o. Other: _____	☐	☐	☐	☐

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 used hands for frequent action such as:

	Simple Grasping	Firm Grasping	Fine Manipulating
a. Right	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
b. Left	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No

6. Client can use head and neck:

	Not at All	Occasionally	Frequently	Continuously
a. Static position	☐	☐	☐	☐
b. Flexing	☐	☐	☐	☐
c. Rotating	☐	☐	☐	☐

7. Restriction of Activities Required by Physical Impairment

☐ extreme cold ☐ extreme heat ☐ wet or humid ☐ slippery floors
☐ vibration ☐ near moving equipment ☐ drive auto/equipment ☐ other: _____

8. Comments/Recommendations

SIGNATURE OF THERAPIST	DATE
SIGNATURE OF PHYSICIAN	DATE