OCCUPATIONAL ADDENDUM

Name: ______________________ ______________________ Date: ________

Providing the requested information will help us understand your present condition and the impact it has had on your life. Your answers will help to guide our examination and will ensure that this functional capacity evaluation is as accurate as possible. If you have any questions as you are completing this worksheet, please place a question mark there and your Clinician will discuss those areas with you.

RECENT HISTORY OF CURRENT CONDITION

During the past year…

1. How many times have you had similar symptoms? *Include episodes that lasted 1 day or more, but the symptoms eventually disappeared completely.*

____

		Yes	No	Comments
2.	Do you ever get pain at the *very tip* of your tail bone?	☐	☐	
3.	Do you ever get pain at the *very top* of your head?	☐	☐	
4.	Do you ever experience pain in your *whole arm*?	☐	☐	Was Does your *whole arm* ever become painful?
5.	Does your *whole arm* ever become numb?	☐	☐	
6.	Do you ever experience pain in your *whole leg*?	☐	☐	
7.	Do you frequently drop things suddenly/unexpectedly?	☐	☐	Was do you suddenly, frequently drop things unexpectedly?
8.	Have you had any periods with little or no pain?	☐	☐	
9.	Have any treatments made your condition worse?	☐	☐	
10.	Have you had any emergency room trips for this?	☐	☐	

EMPLOYMENT OVERVIEW & GOALS

		Yes	No	Comments
11.	Do you have a written job description? *Whom might we contact to get a copy?*	☐	☐	
12.	Does this description accurately reflect actual duties?	☐	☐	
13	How long have you been off work?			
14.	Does your current condition allow you to return to work?	☐	☐	
15.	If no, what work activities are you unable to perform?			
16.	How long have you been off work?			
17.	How many hours do you work?			each day: days/week:
18.	Is a modified work or an alternative position available through your current employer?	☐	☐	

19. What are your goals for returning to work? (Check one.)

Same employer:	☐ same job	☐ modified job	☐ different job
Different employer:	☐ same job	☐ modified job	☐ different job
Other Plans:	☐ get retraining	☐ seek disability	☐ don't know
Other:			

JOB REQUIREMENTS & YOUR CURRENT SITUATION

During a typical 8 hour work period…

REQUIRED LIFTING ON THE JOB	0-10 Lbs	10-20 Lbs	20-35 Lbs	35-50 Lbs	50-75 Lbs	75-100 Lbs	100+ Lbs
Floor to waist level	☐	☐	☐	☐	☐	☐	☐
To shoulder level	☐	☐	☐	☐	☐	☐	☐
To overhead level	☐	☐	☐	☐	☐	☐	☐
Waist-to-Waist (Turning)	☐	☐	☐	☐	☐	☐	☐
Carry items	☐	☐	☐	☐	☐	☐	☐
YOUR CURRENT ABILITY TO LIFT							
Floor to waist level	☐	☐	☐	☐	☐	☐	☐
To shoulder level	☐	☐	☐	☐	☐	☐	☐
To overhead level	☐	☐	☐	☐	☐	☐	☐
Waist-to-Waist (Turning)	☐	☐	☐	☐	☐	☐	☐
Carry items	☐	☐	☐	☐	☐	☐	☐

REQUIRED MOVEMENTS	Never	Under 1 Hr	1 - 2.5 Hrs	2.5 - 5.5 Hrs	Over 5.5 Hrs
Sit	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐
Climb stairs/ladders	☐	☐	☐	☐	☐
Bend/stoop	☐	☐	☐	☐	☐
Squat/crouch	☐	☐	☐	☐	☐
Kneel/crawl	☐	☐	☐	☐	☐
Reach forward	☐	☐	☐	☐	☐
Reach overhead	☐	☐	☐	☐	☐
Operate hand controls	☐	☐	☐	☐	☐
Grasp/handle	☐	☐	☐	☐	☐
Drive	☐	☐	☐	☐	☐
YOUR CURRENT ABILITY TO MOVE					
Sit	☐	☐	☐	☐	☐
Stand	☐	☐	☐	☐	☐
Walk	☐	☐	☐	☐	☐
Climb stairs/ladders	☐	☐	☐	☐	☐
Bend/stoop	☐	☐	☐	☐	☐
Squat/crouch	☐	☐	☐	☐	☐
Kneel/crawl	☐	☐	☐	☐	☐
Reach forward	☐	☐	☐	☐	☐
Reach overhead	☐	☐	☐	☐	☐
Operate hand controls	☐	☐	☐	☐	☐
Grasp/handle	☐	☐	☐	☐	☐
Drive	☐	☐	☐	☐	☐

	Yes	No
21. Do you have family members with health problems that prevent them from working?	☐	☐
22. If yes, are they receiving disability benefits?	☐	☐

– CLINICIAN NOTES –

Clinician: ________

Date: ________