FAX RESULTS TO JIM WILLIS AT 586-623-4149

PHYSICAL CAPACITIES ASSESSMENT

Patient Name:	**Birthdate:**
Social Security #:	**Date you last saw patient:**
Diagnoses:	**Condition:** **__Progressive __Stable** **__Permanent __Temporary**
Identify medical conditions that will effect patient's ability to work:	

Please check the extent of physical capacities below

ACTIVITIES	**NEVER**	**SOMETIMES** (Continuously up to 2 hrs and occasionally up to 6 hrs)	**FREQUENTLY** (continuously up to 8 hrs w/ breaks)
Sit			
Stand			
Lift less than 5 lbs.			
Lift less than 10 lbs.			
Lift less than 25 lbs.			
Lift less than 50 lbs.			
Lift over 50 lbs.			
Bending			
Squat, Crawl, Kneel			
Reach over shoulders			
Grasp on right			
Grasp on left			
Push, Pull			
Stair climbing			

Environmental Restrictions

__Machinery w/ moving parts	__Driving
__Unprotected Heights	__Other:
__Dust, fumes, gases	__Marked temperature or humidity

Have you examined this patient's major body systems in the last 12 months? _Yes _No

Date__________________

What were the findings, if any?

Signature	**Date**
Phone	