PHYSICAL CAPACITIES

CASE NAME	DATE

PATIENT NAME:	CASE NUMBER	SSN:

This form is intended to determine the extent, if any, that this person's current physical condition would interfere with his/her ability to work or participate in a CalWORKs activity. Please address specific functional issues that are relevant to this person's assigned activity, if an assignment is indicated below. Attach additional documentation, if necessary.

This person is assigned to:_____

_____

(Description of nature and hours of assigned CalWORKs activity)

1. In an 8-hour workday, patient can stand/walk: *(Check ✔)* ☐ No Restrictions

   Hours at one time: ☐ 0 - 2 ☐ 2 - 4 ☐ 4 - 6 ☐ 6 - 8

   Total hours during day: ☐ 0 - 2 ☐ 2 - 4 ☐ 4 - 6 ☐ 6 - 8

   Comments:

2. In an 8-hour workday, patient can sit: *(Check ✔)* ☐ No Restrictions

   Hours at one time: ☐ 0 - 2 ☐ 2 - 4 ☐ 4 - 6 ☐ 6 - 8

   Total hours during day: ☐ 0 - 2 ☐ 2 - 4 ☐ 4 - 6 ☐ 6 - 8

   Comments:

3. Is patient restricted in using hands/fingers for repetitive motions? *(Check ✔)* ☐ No Restrictions

   ☐ Yes - please explain _____

4. Is patient restricted in using feet for repetitive movements, such as in operating foot controls? *(Check ✔)* ☐ No Restrictions

   ☐ Yes - please explain _____

5. Is patient restricted by environmental factors, such as heat/cold, dust, dampness, height, etc.? *(Check ✔)* ☐ No Restrictions

   ☐ Yes - please explain _____

PHYSICAL CAPACITIES (CONTINUED)

6. Patient can lift/carry: *(Check ✔)* ☐ No Restrictions

Maximum lbs:	10	15	20	25	30	35	40	45	50	55	60	65	70	75	80+
Never:	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Occasionally (0 - 2.5 hrs/8-hr day)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Frequently: (2.5 - 5.5 hrs/8-hr day)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐
Constantly: (5.5+ hrs/8-hr day)	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

Comments:

7. Patient is able to: *(Check ✔)* ☐ No Restrictions

	Never	**Occasionally** (0 - 2.5 hrs/8-hr day)	**Frequently** (2.5 - 5.5 hrs/8-hr day)	**Constantly** (5.5+ hrs/8-hr day)
Climb	☐	☐	☐	☐
Balance	☐	☐	☐	☐
Stoop	☐	☐	☐	☐
Kneel	☐	☐	☐	☐
Crouch	☐	☐	☐	☐
Crawl	☐	☐	☐	☐
Reach	☐	☐	☐	☐
Below knees	☐	☐	☐	☐
Waist to knees	☐	☐	☐	☐
Waist to chest	☐	☐	☐	☐
Chest to shoulders	☐	☐	☐	☐
Above shoulders	☐	☐	☐	☐

Comments:

8. Is patient involved with treatment and/or medications that might affect his/her ability to work? *(Check ✔)* ☐ YES ☐ NO

If Yes, please explain the limitations/affect:

9. Please describe any other limitations on the individual's ability to work and/or participate in an education/training assignment and accommodations needed:

HEALTH CARE PROVIDER (OR DESIGNEE) SIGNATURE	PHONE NUMBER	DATE
	( )	

HEALTH CARE PROVIDER NAME AND ADDRESS: