

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:

Total hours during day:

0 - 2 2 - 4 4 - 6 6 - 8

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:

Total hours during day:

0 - 2 2 - 4 4 - 6 6 - 8

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:	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Occasionally (0 - 2.5 hrs/8-hr day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Frequently: (2.5 - 5.5 hrs/8-hr day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Constantly: (5.5+ hrs/8-hr day)	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Balance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Stoop	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Kneel	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crouch	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Crawl	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Reach	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Below knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waist to knees	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Waist to chest	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Chest to shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Above shoulders	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

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

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HEALTH CARE PROVIDER NAME AND ADDRESS:
