Residual Functional Capacity Form/Medical Opinion Statement

Patient Name: *Elijah Summers* **Date of Birth:** 12/18/2003
Social Security #: 999-99-9876

Please respond to the following questions regarding your patient's ability to perform work-related physical activities. When answering the questions, please be specific with regards to what evidence in your patient's records supports your opinion. This will be used as medical evidence for a Social Security disability claim or a private long-term disability claim.

Section A: Medical History

1. When did you begin treating the patient?

    January 30, 2004

2. How often do you see the patient?

    Every two months for between 30-45 minutes each appointment.

3. What is your diagnosis of the patient's medical impairment(s)?

    Mr. Summers has talipes equinovarus, commonly referred to as "clubfoot."

4. What is your prognosis for the patient (good, fair, poor)?

    Fair. Since he was a child, Mr. Summers has undergone several complex regional surgeries in both feet in order to correct the congenital deformation. Unfortunately, his surgical interventions have met with limited success, and his feet have not yet healed to the point where we would consider him to have reached maximum medical improvement.

5. Please list the objective medical findings that you use to support your diagnosis:

    Over the years, Mr. Summers has collected significant radiographic evidence of clubfoot, such as X-rays demonstrating midfoot cavus (excessively high arches), forefoot adductus ("pigeon toe"), and hindfoot varus and equinus (abnormal angulation of the heel and ankle). Several MRIs also show surgical fusion and osteotomy in the foot joints. The deformation is also evident on visual inspection, as Mr. Summers' feet are fairly severely turned inward.

6. Please describe any treatment the patient has completed so far and the results of the

treatment:

Mr. Summers has undergone several surgical interventions as well as more conservative treatment modalities such as stretching and casting (the "Ponseti method") . He uses custom orthotics (special shoes) and braces in order to help him walk.

Section B: Signs and Symptoms

7. Please identify the medical signs, present on physical examination, of your patient's impairment(s):

Mr. Summers has a visible deformity of his bilateral lower extremities. He evinces tenderness to palpation and edema (swelling) of his feet and toes, which are cool to the touch. He has a reduced range of motion (ROM) in his ankles of 20 degrees plantar flexion (normal 40 degrees), 10 degrees dorsiflexion (normal 20 degrees). In his feet, Mr. Summer has a reduced ROM of 15 degrees inversion (normal 30 degrees) and 10 degrees eversion (normal 20 degrees).

8. Please identify the symptoms of your patient's impairment(s):

Mr. Summers reports pain, numbness, and weakness in his feet and ankles. He has significant difficulty walking without assistance.

Section C: Functional Limitations

9. Does your patient have limitations in their ability to stand? __✓_ Yes _____No

If yes, please circle the number that best describes the total amount your patient can stand in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can stand at one time before they need to sit down (in minutes or hours)?

10-15 minutes.

10. Does your patient have limitations in their ability to walk? __✓_ Yes _____No

If yes, please circle the number that best describes the total amount your patient can walk in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can walk at one time before they need to sit down (in minutes, hours, or distance)?

5-10 minutes.

Does your patient require an ambulatory aid, such as a walker or cane?

__✓_ Yes _____No

12. Does your patient have limitations in their ability to sit? __✓_ Yes _____No

If yes, please circle the number that best describes the total amount your patient can sit in an 8-hour workday:

Less than 2 hours 2 hours 4 hours 6 hours

What is the longest your patient can sit at one time before they need to get up (in minutes or hours)?

Mr. Summers experiences swelling and pain in his feet if he is seated in an upright position for longer than one hour.

13. Does your patient have limitations on lifting and carrying? __✓_ Yes _____No

If yes, please circle the number that best describes the heaviest amount, in pounds, that your patient can lift or carry *occasionally* (up to 1/3 of the workday):

Less than 10# 10# 20# 50# 100#

Please circle the number that best describes the heaviest amount, in pounds, that your patient can lift or carry *frequently* (up to 2/3 of the workday):

Less than 10# 10# 20# 50# 100#

14. Does your patient need to be able to change positions at will? _✓_ Yes _____No

If yes, how often do you think your patient will need to shift positions during the workday?

If standing, Mr. Summers will need to sit down every 10 minutes for about 5 minutes each time. If seated upright, he will need to stand up and move around for 10 minutes every hour.

15. Does your patient need to be able to lie down during the day? __✓_Yes ____No

If yes, how often do you think your patient will need to lie down during the day and for how long?

Mr. Summers should be able to lie down (or elevate his legs) for at least 45 minutes every four hours.

16. Does your patient need to be able to elevate their legs? _✓_ Yes _____No

If yes, how long does your patient need to elevate their legs for and at what height (e.g., at waist level)?

Mr. Summers should be able to elevate his legs (or lie down) for at least 45 minutes every four hours to relieve pain.

17. Please check the box that best describes how often your patient can perform the following actions in an 8-hour workday:

	Rarely or Never (very little, if at all)	Occasionally (up to 1/3 of the day)	Frequently (1/3-2/3 of the day)
Twist	☐	☐	☒
Bend	☐	☒	☐
Crouch	☒	☐	☐
Climb stairs	☐	☒	☐
Climb ladders	☒	☐	☐
Kneel	☒	☐	☐
Crawl	☒	☐	☐
Balance	☐	☒	☐

18. Does your patient have limitations in the upper extremities? _____ Yes _✓__No

If yes, please check the box that best describes how often your patient can use their arms, hands, and fingers to perform the following activities:

	Rarely or Never (very little, if at all)	Occasionally (up to 1/3 of the day)	Frequently (1/3-2/3 of the day)

Reaching overhead	☐	☐	☒
Reaching laterally	☐	☐	☒
Handling	☐	☐	☒
Fingering	☐	☐	☒
Feeling	☐	☐	☒
Grasping	☐	☐	☒

19. Are your patient's symptoms exacerbated by exposure to certain environmental conditions? _✓_ Yes _____No

If yes, please check the box that best describes how often your patient should come into contact with the following factors:

	Avoid All Exposure	Avoid Moderate Exposure	Avoid Concentrated Exposure	No Restrictions
Extreme cold	☐	☐	☒	☐
Extreme heat	☐	☐	☒	☐
Wetness	☐	☐	☒	☐
Humidity	☐	☐	☒	☐
Noise	☐	☐	☐	☒
Fumes or gases	☐	☐	☒	☐
Hazards	☒	☐	☐	☐
Heights	☒	☐	☐	☐

20. Does your patient experience pain? _✓_ Yes _____No

If yes, please describe the location, intensity, and frequency of the pain:

Mr. Summers experiences a constant dull, throbbing pain in his feet and ankles. About several times per day, he experiences a shocking, electric pain in his toes.

21. Do your patient's symptoms affect the ability to concentrate or maintain attention? _✓_ Yes _____No

In addition to the pain, Mr. Summers has side effects from his medication that causes him to feel mentally foggy, especially during mornings.

If yes, please circle the percentage that best reflects how much of the workday these symptoms would be severe enough to interfere with tasks:

5% 10% 15% (20%) 25% Over 25%

22. Do your patient's symptoms result in "good days" and "bad days"? _✓_ Yes _____No

23. Would your patient's symptoms or treatment result in absences from work?
_✓_Yes _____No

If yes, please circle the amount that best represents how often your patient would miss work per month:

Less than one day One day (Two days) Three days More than three days

Section D: Professional Observations

24. Has your patient cooperated with your treatment recommendations? __✓_ Yes ____ No

If not, please explain why your patient was unable to follow the recommended treatment:

25. Does your patient have a history of drug or alcohol abuse? _____ Yes __✓_ No

If yes, would your patient's symptoms exist or persist despite drug or alcohol use?
_____ Yes _____No

26. Does your patient exaggerate symptoms? _____ Yes _✓_ No

27. Do you expect the patient's limitations to last at least one year? _✓_ Yes _____No

28. On what date did these limitations begin?

Mr. Summers has had this disorder since birth. As his pediatrician who is helping Mr. Summers make the transition to an adult podiatrist (foot doctor), I would describe these limitations to the new provider as being in existence on his 18th birthday, which is December 11, 2021.

29. In your opinion, are your patient's limitations reasonably consistent with the objective medical evidence and physical evaluations as a whole? _✓_ Yes _____No

Doctor's Name and Signature: Baxter DuBois, M.D. **Date:** April 8, 2025

Baxter DuBois, MD

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