

**Your Doctor or Insurance has ordered that you undergo a  
Functional Capacity Evaluation**

**What is it?**

**A Functional Capacity Evaluation (FCE) is a 2.5 to 4.0 hour-long exam administered by a licensed therapist to determine your ability to perform work.** This exam looks at your safe abilities to lift, push, pull, twist, bend, climb, stand, walk, etc. and perform other movements similar to work requirements. This is then compared to what you actually do at work to see if you can return safely.

**What you need? -- Please Read**

1. Paperwork from us or your M.D. and complete it ***prior*** to arriving for the exam.
2. Loose fitting clothes and athletic shoes.
3. Your job description from your supervisor. Please ask your employer for a job description.
4. Your doctor's prescription unless he has sent it already.
5. General medical history and current medical history.
6. Medical clearance from your doctor if you have heart, lung or blood pressure problems.

**Other information**

1. Children or anyone who would not be able to wait for 2-4 hours are discouraged from coming with you.
2. Water, coffee or towels – supplied.
3. Please be on time since this test takes most of the morning. Most tests start at 8:00 sharp. Call to find out what time your exam will be.

Directions:

We are in the San Mar Plaza (next to Hastings) off of Hwy 80 (exit 205). San Mar Plaza is on the East side of IH-35. Our number is 512-353-4575

**PERSONAL IDENTIFICATION INFORMATION**  
for  
**Functional Capacity Evaluation**  
(Please Print)

**GENERAL INFORMATION**

Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Street Address \_\_\_\_\_ Mailing Address \_\_\_\_\_

City,State,Zip Code \_\_\_\_\_ Social Security Number \_\_\_\_\_

Sex \_\_\_\_\_ Age \_\_\_\_\_ Birthdate \_\_\_\_\_ Job Applying For \_\_\_\_\_

Closest relative not in your home \_\_\_\_\_ Home Phone \_\_\_\_\_

Address \_\_\_\_\_ City,State,Zip Code \_\_\_\_\_

If Married, Spouse's Name \_\_\_\_\_ Birthdate \_\_\_\_\_

Social Security No. \_\_\_\_\_

Spouse's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

If minor, Parent's or Guardian's Name \_\_\_\_\_ Home Phone \_\_\_\_\_

Parent's or Guardian's Employer \_\_\_\_\_ Business Phone \_\_\_\_\_

**INFORMATION ABOUT THE COMPANY (that the test is for):**

Name \_\_\_\_\_ Business Phone \_\_\_\_\_

Street Address \_\_\_\_\_ Mailing Address \_\_\_\_\_

City,State,Zip Code \_\_\_\_\_ Yard location (City) \_\_\_\_\_

Mailed \_\_\_\_\_

Faxed \_\_\_\_\_

By Whom \_\_\_\_\_

# FUNCTIONAL CAPACITY EVALUATION CONSENT FORM

## Instructions and Consent for Testing

You are going to undergo a “Functional Capacity Evaluation” which is a series of tests of strength, flexibility, endurance, cardiovascular fitness, material handling ability, coordination, static posturing, repetitive movements, and any other tests which will help your good safe ability to work. All the tests are voluntary and you may refuse any test if you feel you are not capable of performing it. All tests will be thoroughly explained to you before you are asked to perform them.

There are certain inherent risks with a Functional Capacity Evaluation because you will be asked to exert effort, handle weights, and perform activities with increasing degrees of difficulty which could cause an increase in your current level of pain and discomfort, or an aggravation to your existing injury.

You should attempt to stop each test before you experience any increase in your current level of pain or discomfort. You are expected to cooperate fully with the evaluator in order to stop each test before any increase in your current level of pain or discomfort. You are expected to continue each test until your Good Safe Level of Work has been determined and you are expected to cooperate to the best of your ability to help determine your true capabilities.

The evaluator will take every precaution to insure that you are protected from any potentially hazardous situations and you will never be forced to perform any test which you do not wish to perform.

Based on the above information I agree to cooperate fully and to participate in the Functional Capacity Evaluation to help determine my actual safe working ability. I, hereby, authorize representatives of \_\_\_\_\_ to release this information to the appropriate parties as a part of my medical record and I, hereby, authorize representatives of \_\_\_\_\_ to provide any information from this test to my employer at the request of my employer. Furthermore, I agree that a copy of the written report prepared as a result of this test may be provided to my employer upon his/her request.

Date: \_\_\_\_\_  
Patient's Signature

Date: \_\_\_\_\_  
Evaluator's Signature

Please Read and Sign...

Authorization for Treatment/Testing

I hereby request and authorize treatment/testing from \_\_\_\_\_ and associates or assistants of their choice.

X \_\_\_\_\_  
Signature

**Authorization to Release Information**

I hereby authorize \_\_\_\_\_ to release complete information acquired in the course of my prescribed treatment or requested testing to my insurance carrier or its representatives, my attorney, or the physician treating me. I hereby authorize \_\_\_\_\_ to provide information for any services rendered to me by \_\_\_\_\_ to my employer at the request of my employer.

Furthermore, I agree that a copy of any written documentation prepared as a result of any services rendered to me by \_\_\_\_\_ may be provided to my employer upon request. A photocopy of this authorization shall be considered as effective and valid as the original. I understand I have the right to receive a copy of this authorization.

X \_\_\_\_\_  
Signature

**Consent to Taking of Photographs**

I hereby authorize \_\_\_\_\_ and associates or assistants to take photographs of me as part of the requested testing, or if I should become a patient, during the course of my medical treatment. These photographs shall be used for identification purposes for testing only. In the event that I might subsequently become injured, I agree that these photographs may be used for medical records as deemed necessary.

X \_\_\_\_\_  
Signature

Date: \_\_\_\_\_ Witness: \_\_\_\_\_

## McGill Pain Questionnaire

Patient Name: \_\_\_\_\_

Date: \_\_\_\_\_

Use the single BEST word in each group that most accurately describes your CURRENT pain. If none are applicable, leave that box BLANK and move to the next category. If you have any questions, remain seated and wait for assistance.

|  |  |  |  |
|--|--|--|--|
| 1 Flickering<br>Quivering<br>Pulsing<br>Throbbing<br>Beating<br>Pounding | 6 Tugging<br>Pulling<br>Wrenching            | 11 Tiring<br>Exhausting                                  | 16 Annoying<br>Troublesome<br>Miserable<br>Intense<br>Unbearable |
| 2 Jumping<br>Flashing<br>Shooting  | 7 Hot<br>Burning<br>Scalding<br>Searing      | 12 Sickening<br>Suffocating                              | 17 Spreading<br>Radiating<br>Penetrating<br>Piercing             |
| 3 Pricking<br>Boring<br>Drilling<br>Stabbing<br>Lancinating              | 8 Tingling<br>Itchy<br>Smarting<br>Stinging  | 13 Fearful<br>Frightful<br>Terrifying                    | 18 Tight<br>Numb<br>Drawing<br>Squeezing<br>Tearing              |
| 4 Sharp<br>Cutting<br>Lacerating   | 9 Dull<br>Sore<br>Hurting<br>Aching<br>Heavy | 14 Punishing<br>Gruelling<br>Cruel<br>Vicious<br>Killing | 19 Cool<br>Cold<br>Freezing                                      |
| 5 Pinching<br>Pressing<br>Gnawing<br>Cramping<br>Crushing                | 10 Tender<br>Taut<br>Rasping<br>Splitting    | 15 Wretched<br>Blinding                                  | 20 Nagging<br>Nauseating<br>Agonizing<br>Dreadful<br>Torturing   |

PRI: S \_\_\_\_\_ A \_\_\_\_\_ E \_\_\_\_\_ M \_\_\_\_\_

TOTAL: \_\_\_\_\_

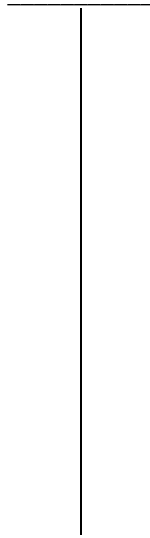
Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

## Visual Analog Scale

### Instructions

Imagine this vertical line as a thermometer which registers your pain. The top of the line is “Pain as bad as it can be” while the bottom is “No pain at all.” Make a horizontal mark (-) between these two extremes at the height you feel best represents your current pain level to your major area of injury.

“Pain as bad as it can be”



“No pain at all”

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

### PAIN RATING

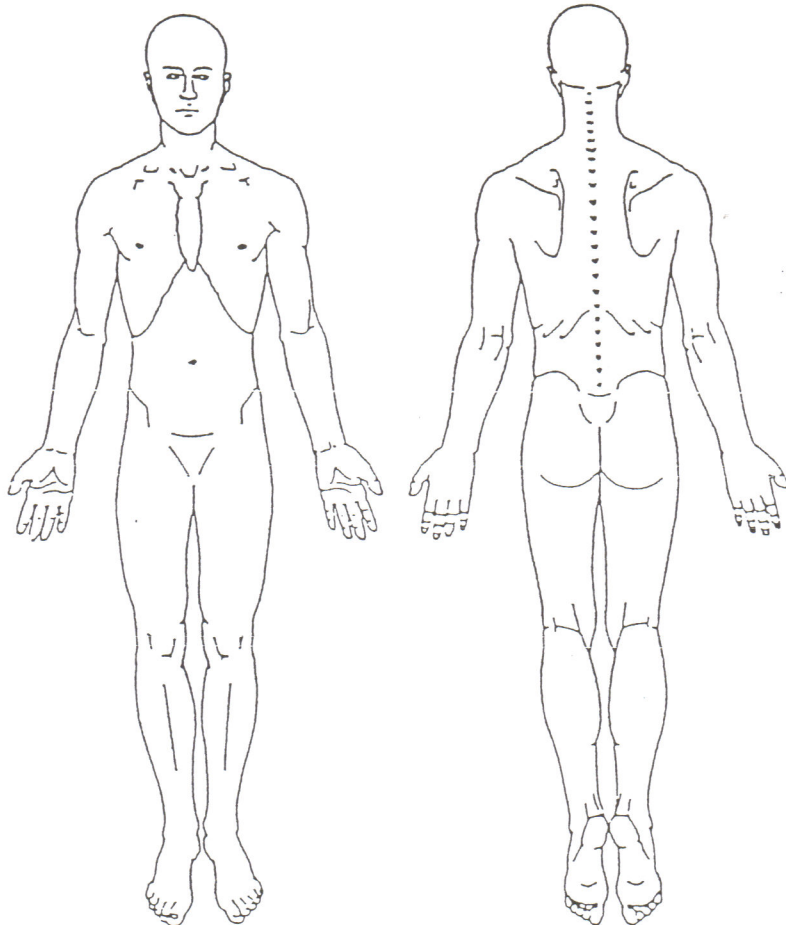
Please rate your major area of pain on a scale of 0 to 10 by writing the number of your pain, that corresponds to the appropriate word descriptors at the present time, as well as your best and worst over the past 30 days.

|                |                  |                 |               |                    |                          |                                  |
|----------------|------------------|-----------------|---------------|--------------------|--------------------------|----------------------------------|
| <u>No Pain</u> | <u>Weak Pain</u> | <u>Moderate</u> | <u>Strong</u> | <u>Very Strong</u> | <u>Very, Very Strong</u> | <u>Emergency/Hospitalization</u> |
| 0              | 1-2              | 3-4             | 5             | 6-7                | 8-9                      | 10                               |

### PAIN DRAWING

#### Instructions

Please shade all areas of discomfort caused by your current injury.



# Ransford Pain Drawing

## INSTRUCTIONS

Indicate where your pain is located and what type of pain you feel at the present time. Use the symbols below to describe your pain. Do not indicate areas of pain which are not related to your present injury or condition.

### KEY

/// Stabbing

XXX Burning

000 Pins and Needles

=== Numbness

