Essential Job Function Questionnaire

Patient Name:_____ Date:_____

Employer Name:_____ Job Title:_____

The purpose of this questionnaire is to help identify the specific physical demands of your job. Please be as specific as possible and circle or write in appropriate answer.

Lifting:

Do you need to lift items or product at your job? Yes No

What is the heaviest amount of weight you need to lift by yourself?_____

Do you need to lift from the ground? Yes No

Do you need to lift overhead? Yes No

How frequently do you need to lift this weight during your average work day?

1-5x per hour >5x per hour 5-10x per hour >10x per hour

Carry:

Do you need to carry objects/items at work? Yes No

What is the heaviest amount of weight you need to carry by yourself?_____

How far do you need to carry this weight?_____

Do you carry with one hands or two hands? One hand Two hands

How often do you need to carry this weight during your average work day?

1-5x per hour >5x per hour 5-10x per hour >10x per hour

Push/Pull:

Do you need to push/pull objects/items at work? Yes No

What is the heaviest amount of weight you need to push/pull by yourself?_____

How far do you need to push/pull?_____

How often do you need to push/pull this weight during your average work day?

1-5x per hour >5x per hour 5-10x per hour >10x per hour

Climbing:

Do you need to climb stairs? Yes No

Do you need to climb ladders? Yes No

How many steps/rungs?_____

How many times per day?

1-5x per hour >5x per hour 5-10x per hour >10x per hour

Sitting: Does your job require you to sit? Yes No

If you answered "Yes", how long must you sit at one time?_____

Standing: Does your job require you to stand? Yes No

If you answered "Yes", how long must you stand at one time?_____

Walking: On average, how far do you think you walk during your work day?_____

Gripping/Pinching: Do you need to grip or pinch tools or objects? Yes No

Are you right or left handed? Right Left

Are both hands required for your job? Yes No

Do you need to use your arms and hands in a repetitive manner?_____

Postures: Does your job require you to squat? Yes No

Does your job require you to reach overhead? Yes No

Does your job require you to crouch in confined spaces? Yes No

Does your job require you to bend at the waist? Yes No

Personal Protective Equipment (PPE)/Tools: Please list any PPE or tools you must wear or use at your job:

Other: Please list any other activities you need to do at work that you would be unable to perform or that would be difficult to do with your current injury:

I acknowledge that my answers to these questions most accurately depict the essential functions of my job. I have answered the questions based on my knowledge and recollection and the answers may be used to establish my Physical Therapy or Occupational Therapy goals and plan.

Patient Signature:_____ Date:_____

Primary Clinician Signature:_____