Script for Setting the Stage and Introducing the Functional Capacity Evaluation

Clinician:
Do you know what we're doing here today?

Client:
Not really?

Clinician:
We're here to do a functional capacity evaluation which is an assessment of your abilities and limitations. We'll start with an interview so I can find out what things you are able to do and what things you are having difficulty doing. After the interview we do a series of tests that look at your ability to do things such as lifting, carrying, pushing and pulling, and how well you can work in various positions such as sitting, standing, and bending. The tests are fairly straight forward but there are 2 things I need from you in order for me to be able to confidently report on your abilities and limitations and to deal with any potential challenges to this assessment.

The first thing I'm asked to address is how do I know the results are reliable. The way I deal with this is to ask you to give your best effort throughout the evaluation. I then measure your effort using tests such as heart rate monitoring which you will wear during the assessment; consistency tests (where I test the same thing in different ways to see if the results are reliable) and distraction tests (tests where it looks like I'm testing one thing but it's really testing another). If you give your best effort then the results should be reliable and my opinions on your abilities and limitations are more difficult to challenge.

Now there may be some tests in which you can't give full physical effort, for example if you're concerned about hurting yourself, or you're having too much pain - I just need you to let me know and also for you to tell me the reason why you can't give full effort so I can understand (and document) what the limitation is.

The second thing I often get asked is How do I know a client's reports of pain or disability are reliable, especially given that pain can't be measured. So to deal with this question, I'd like to ask you to be accurate in describing your pain, don't feel you need to minimize or over emphasize your pain and limitations. I will respect what you tell me.

The way I deal with the question is to have you rate the effect of your pain on your functioning (on the functional pain scale – show the scale) and then I can see whether your ratings are similar to what I observe during testing. I also do some placebo tests (tests that look like they cause pain but we know that they don't). If you are accurate in describing your pain and the effect on your abilities I'm able to put this in my report and there is less ability for this opinion to be challenged.

Do you see any problems with this, or do you have any questions or concerns?

NOTE:
It is also helpful to tell the client, when introducing the FCE, that you will work to be objective and fair and to make sure that they are safe during the evaluation. After asking them to give full effort and reliable reports this is your commitment back to them.
NOTE:
You may want to customize this script depending on the person, their injury and the referral questions.

Informed Consent for Functional Capacity Evaluation

Explanation of the Functional Capacity Evaluation

You have been referred to _____
to provide an independent opinion as to your functional status. The purpose of this evaluation is to more clearly document your abilities and limitations relative to work and daily activity. This is a voluntary evaluation, performed with your consent. Your testing will include functional activities to better address your tolerances for sitting, standing, strength, and body mobility.

Your Responsibilities
To ensure your safety and value of this evaluation, it is your responsibility to fully disclose information you have pertaining to your past and current health, to work safely during the evaluation and to report any increase in sensations during the evaluation.

Benefit to be Expected
The results obtained from this evaluation will assist in evaluating what type of physical activities you might do with low risk of harm. If you have a job to return to, it will assist you in returning to that job safely.

It is important that you provide your **best effort** during today's testing so that we are able to accurately determine your physical abilities and subsequent physical limitations. You will be asked regularly about how you are feeling and what you can and cannot do. It is important that you **attempt to provide an accurate portrayal** of your symptoms and not overstate or understate your abilities and limitations.

Inquiries
Any questions about the procedures used in the exercise test or in the estimation of functional capacity are encouraged. If you have any concerns or questions, please ask us for further explanations now or at any time during the evaluation.

Freedom of Consent
I have read this form and I understand the evaluation procedures that I will perform. I consent to participate in this evaluation and understand that I may stop the evaluation at any time if I am unable to continue.

Signature of Participant_____**Date**_____

Evaluator_____**Date**_____**Time**_____

The Client - Matheson Functional Capacity Evaluation

1a. Client Name and Address

First_____Middle Initial_____Last_____

Address_____

City _____State/Province_____ Zip/Postal Code_____

Home Phone _____Cell Phone _____

Additional Information

Birth Date (mm/dd/yyyy)_____ Height _____ in. / cm. Weight _____ lbs / kgs

Gender: Male_____ Female_____ Dominance: Right_____ Left_____

Social Security No. _____Claim No. _____

1b. Intake By:

First _____ Last _____Suffix _____

Organization_____

City _____State/Province _____Zip/Postal Code _____

Telephone_____Cell_____

Email_____

1c. Date of Injury / Diagnosis

Date of Injury:_____

Diagnosis_____

_____

_____

_____

Client's Description of Injury:

_____

_____

_____

_____

_____

_____

1d. Records

Description of Record	**Dates**
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

_____

COMMENTS:

_____

_____

_____

_____

1e. Treatment Precautions/Contraindications

Previous Treatment **Approx. Date Results**

Physical Therapy _____ _____

Comments_____

Occupational Therapy _____ _____

Comments_____

Pain Program _____ _____

Comments_____

Chiropractor _____ _____

Comments_____

Psychological Therapy _____ _____

Comments_____

Biofeedback _____ _____

Comments_____

Massage Therapy _____ _____

Comments_____

Acupuncture _____ _____

Comments_____

Other _____ _____

Comments_____

1f. Investigations Yes Current Date Results/Comments Injury

X-Ray_____

CT Scan _____

MRI _____

EMG _____

Blood Test_____

Myelogram _____

Bone Scan _____

2. Worker's Narrative

Referral Matheson Functional Capacity Evaluation

3a. Referred By:

First _____ Last _____Suffix _____

Organization_____

Address_____

City _____State/Province _____ Zip/Postal Code_____

Telephone _____Fax _____

Email Address_____

3b. Referral Questions

Physical Effort Questions:

a. Did the Client demonstrate high levels of Physical Effort during the testing day?

Reliability of Reports Questions:

a. Are the Client's reports of pain and disability reliable?

Return to Work Questions:

a. Is the Client able to return to his/her pre-injury job? If not what can they do?

b.

c.

Other Questions:

a.

b.

c.

Evaluated By:

First _____ Last _____ Suffix _____

Organization _____

Address _____

Address _____

City _____State/Province _____ Zip/Postal Code _____

Telephone _____Fax_____

Email Address _____ CWCE # _____

Matheson Functional Capacity Evaluation

Referral

Paid By:

First _____Last _____

Organization Address_____

City _____State/Province _____Zip/Postal Code_____

Telephone_____ Fax_____

Email_____

Matheson Functional Capacity Evaluation Software©

Medical History

1. The Client

A. Medical History (Check All That Apply)

	Night Sweats or Fever		Mouth Sores		Back Injury		Any Lung Problem
	Recent Weight Loss/Gain		Change In Voice		Joint Injury/Pain		Shortness of Breath
	Convulsions		Hoarseness		Arthritis		Hay Fever
	Memory Loss		Difficulty Swallowing		Broken Bones		Asthma
	Numbness/Tingling		Heart Problems		Blood Disease		Bronchitis
	Fainting/Dizzy Spells		Chest Pain		Bleed Easily		Pneumonia
	Headaches		Rheumatic Fever		Anemia		Tuberculosis
	Paralysis		Irregular Heart Beat		Diabetes		Persistent Cough
	Stroke/Blood Clot		Heart Murmur		Thyroid Problems		Cough Up Blood
	Wear Glasses		High Blood Pressure		Cancer		Smoker/Ex-Smoker
	___ Reading		Swollen Ankles		Change In Wart Or Mole		___ Years
	___ Distances		Varicose Veins		Liver Disease		___ Cigarettes (Pk/Day)
	___ Contact Lenses		Ulcers		Drinks Alcohol		___ Pipe (Bowls/Day)
	Other Vision Problems		Change In Bowels Or Bladder		__ Drink Per Day		____ Quit (Year)
	Color Blindness		Hernia		__ Drinks Per Week		Exposed to Second-Hand Smoke?
	Cataracts		Nausea/Vomiting (Other Than Flu)		Trouble Sleeping		Other
	Glaucoma		Blood In Urine		Stress		
	Hearing Problems		Kidney Problems		Depression		
	Noise In Ears		Bladder/Reproductive Infections		Prior Drug/Alcohol Treatment		
	Balance Problems						
	Sinus Problems						

B. Physician

Name _____ **Practice** _____

Address _____

City _____**State/Province** _____ **Zip/Postal Code** _____

C. Surgeries

Date	Surgery

D. Allergies

_____

_____

_____

E. Medications

Prescription	Non-Prescription

F. Medical Devices

G. Additional Medical History

H. Work Environment

	Construction Site		Fiber Mill / Foundry		Refinery		**Hazardous Exposures (List):**
	Cotton, Flax or Hemp Mill		Mine		Dusty Jobs		
	Electronics Plant		Paper / Lumber Mill		Chemical Plant		

Chemical Exposure

	Arsenic		Chromates		Phenols
	Asbestos		Large Amounts of Dust		Plastics
	Benzene		Lead		PCB's
	Berylilium Florides		Loud Noises		Repetitive Motion/Vibration
	Cadmium		Spray Paints		Solvents/Degreasers
	Carbon Tetrachloride		Lasers		Trichoroethylene
	Extreme Changes In Temperature		Pesticides		Welding/Soldering
	Mercury/Other Heavy Metals		Fluorides		Radioactive Materials

I. Hurt or Injured on Prior Job(s)

Job	Description

Job History

From Date	To Date	Position / Job Duties	Company

Work History Comments

J. Home Environment

Lives With: ❑ Husband/Wife ❑ Partner ❑ Alone ❑ Family ❑ Housemate _____ No. of Children

Lives In: ❑ Single Level ❑ Multi Level Home ❑ Mobile Home ❑ Townhome ❑ Apartment

Current Level of Activity

❑ Negligible; Requiring Daily Naps ❑ Sedentary ❑ Moderate ❑ Very Active

Level of Education Completed: _____

Location: _____

K. Hobbies

	Gardening/Yard Work		Woodwork/Carpentry/Home Repair		Tennis/Golf/Racquetball
	Sewing/Needlepoint		Use Chainsaw/Power Tools/Jack Hammer		Weight Lifting
	Knit/Crochet/Embroidery		Play Musical Instrument		Aerobic Exercise
	Bicycling/Motorcycling		Write/Type/Computer		Hunt/Fish/Shoot

Other Hobbies	

The Functional Tolerance Profile

The Functional Tolerance Profile (FTP) also referred to as Client's Estimate of Maximums in the Matheson FCE Software is a very important tool, which when performed correctly serves as a comparison point throughout the FCE in reference to the client's Reliability of Pain and Disability Reports. It is critical that the evaluator learn to perform this interview correctly, as when it is performed incorrectly it is a waste of testing time.

The value of this tool is the comparison of the client's subjective reports to objective findings to examine the consistency of this information throughout the FCE. Furthermore, the Thinking Evaluator will use the conversation around this tool to begin forming a picture of how the client views him/herself in terms of ability/limitations. Additionally, if the client is Reliable in reporting their abilities and limitations, the evaluator can use these functional reports to assist in determining the client's level of ability/limitation. If the client is unreliable, then less weight should be given to this subjective information. Prior to beginning the FTP, familiarize yourself with the client's medical history and diagnosis.

Using the FTP form, or the Matheson FCE Software, interview the client in regard to his/her physical abilities and limitations and find out the reason for any limitations, (e.g., is it due to pain, weakness). The evaluator should be careful not to create too much focus on lengthy descriptions of symptoms for each area of limitation as long descriptions of symptoms do not add value to the FCE.

Procedure

1. Review each Physical Demand asking, for example, "When it comes to lifting, do you have any limitations?" and "How much weight can you lift?" or "How much can you lift on a dependable basis?"

2. If the client is unaware of his or her ability, follow up with a question like, "Do you do your own grocery shopping? What types of items are difficult to lift?"

3. When a limitation is expressed by the client, quantify specifics regarding weights, times, distances, and repetitions; (e.g., Asking if they can lift a ¼, ½, or 1 gallon container of milk is helpful for low functioning clients as each ¼ gallon is about 2 pounds). For sitting tolerance you can ask questions like – "what is the longest time you have travelled in a car?" "Did you take any breaks during this trip?" "How many?"

4. When a limitation has been presented by the client, the interview should continue with the evaluator asking specifics regarding the reasons a physical ability is difficult (e.g., pain, fatigue). It is also helpful to find out what the client does to manage their pain and functional limitation so you can observe to see if this is consistent with the client's presentation during the evaluation.

5. Next, to be of value as a comparison point throughout the FCE, ask questions that will encourage the client to describe the symptoms they experience while performing the various functional tasks. For example “When I sit for longer than 10 minutes I get a burning pain and tingling and I have to get up and walk around to relieve the symptoms.” The evaluator will then look for consistency in the time spent sitting prior to symptom report or change in function. Noting the client’s reported need to alter function to relieve symptoms and the client’s *actual* function changes will help to further compare the client’s subjective reports with objective findings and observations.

6. A well-documented description, including information as presented in the following example, will allow the evaluator to compare subjective and objective information strengthening the RPDR Profile.

“I can only sit for 15 minutes at a time because my left leg becomes numb and my low back falls asleep. When I stand, the pain shoots down my leg to my ankle and I have to take a few minutes to stretch. After I do this I can stand and walk without difficulty. I can return to sitting after about 10 minutes of being on my feet.” This information can be compared to later performance in the clinic. (Note that if the client is currently in a seated position his limitation should manifest if he remains seated for more than 15 minutes).

Functional Tolerance Profile

Name: _____Date: _____

Position	Client's Estimate	Limited by (Sx, be specific)
Sitting:		
Standing:		
Walking:		
Climbing:		
Balance:		
Stooping:		
Kneeling:		
Crouching:		
Reaching:		
Lifting:		
Carrying:		
Handling:		
Fingering:		
Feeling:		
Driving:		

Reported Functional Tolerances

	Client's Estimate of Current Ability	Limited By
Position		
Static Standing		
Dynamic Standing		
Walking		
Sitting		
Weight/Force		
Lifting 1 Floor to Knuckle		
Lifting 2 Knuckle to Shoulder		
Lifting 3 Shoulder to Overhead		
Carrying		
*Pushing		
*Pulling		
Agility		
Climbing		
Balancing		
Stooping		
Crouching		
Crawling		
Twisting/Spinal Rotation		
Low-Level Work		
Prolonged Neck Positioning		

Dexterity		
Reaching Forward		
Handling		
Fingering		
Above-Shoulder Work		
Pinching		
Writing		

Client's Work-Related Goals

4a. Employed By

Organization _____

Address _____

Address _____

City _____State/Province _____ Zip/Postal Code _____

Telephone_____Fax _____

Email Address_____

Job at Time of Injury: _____

Is the client working for the above employer at present? _____ Yes _____ No

IF YES:

_____ Full-Time _____ Part-Time _____ Light Duty _____ Modified Duty _____ Other

How long has the client been at this job? _____

IF NO:

What is the date the client last worked? (mm/dd/yyyy) _____

4 b.

Target Job _____

Actual Hours of Work (Enter Hours or Minutes)

	Hours	Minutes
Typical Work Day	_____	_____
Lunch Break	_____	_____
Other Break	_____	_____
Other Break	_____	_____
Net Time Worker	_____	_____

Job Analysis Demands Data Obtained From:

- ❑ Job Analysis Performed by _____
- ❑ The National Occupational Classification System
- ❑ O*Net
- ❑ The Dictionary of Occupational Titles
- ❑ MOS
- ❑ Other _____

Task Statements Obtained from Interview With:

- ❑ Employer on: _____ (mm/dd/yyyy)
- ❑ Direct Supervisor on: _____ (mm/dd/yyyy)
- ❑ Employee on: _____ (mm/dd/yyyy)

4c. Demands of Target Job

Position

	Low Range (min)	High Range (min)	PDL Frequency
Static Standing			
Dynamic Standing			
Sitting			
Walking			
Distance: _____Conditions: _____			

Weight/Force

	Weight	Range	Frequency	Duration	Surface?	PDL Frequency
Lifting						
Lifting						
Lifting						
Carrying						
Pushing						
Pulling						

Agility

	Frequency	Duration	PDL Frequency
Climbing			
Height: _____ Structure/Ladder Type: _____ Steepness: _____			
Balancing			
Activities:			
Stooping			
Crouching			
Crawling			

Distance: _____			
Twisting/Spinal Rotation			
Low-Level Work			
Range: _____ to _____			
Prolonged Neck Positioning			

Dexterity

	Frequency	**Duration**	**PDL Frequency**
Reaching Forward			
Handling			
Fingering			
Above-Shoulder Work			
Range _____ to _____			
Pinching			
Writing			
Driving			

Job Demand Interview Form

The purpose of this interview is to get detailed information about the client's job tasks so the evaluator can more closely compare the FCE results with the client's Job Demands. This match will enhance the Validity and Utility of the FCE.

TASK	**TIME** **Min-Max**	**DISTANCE** **Min-Max**	**WEIGHT** **Min-Max**	**COMMENTS** **(What is lifted, moved, handled)**
Sitting				
Standing				
Walking				
Lifting				
Lifting				
Lifting				
Carrying				
Pushing				
Pulling				
Climbing				
Balancing				
Stooping				
Crouching				
Crawling				

Low Level Work				
Prolonged Neck Positioning				
Reaching				
Handling				
Fingering				
Feeling				
Above Shoulder Work				
Pinching				
Writing				
Driving				