Job Demands Questionnaire

The U.S. Department of Labor recognizes 20 common activities related to employment. 16 of those are most commonly assessed as part of a Functional Capacity Evaluation (FCE). Seeing, Hearing, Talking and Feeling are not typically included. As part of the evaluation, please complete the form below using the criteria listed. Please note that this relates to your specific job demands prior to your injury, not what you are capable of doing now. If you have any questions, please direct them to your evaluator at the time of your FCE.

Work Frequency is defined as follows:

	% OF THE WORKDAY	HOURS IN AN 8 HOUR DAY	REPETITIONS
CONSTANT	67%-100% OF THE DAY	6-8 HOURS	>500 TIMES
FREQUENT	34%-66% OF THE DAY	3-6 HOURS	100-500 TIMES
OCCASIONAL	1-33% OF THE DAY	UP TO ~ 3 HOURS	<100 TIMES
NEVER	0% OF THE WORK DAY	0	0

To the best of your ability, please report below the physical demands of your pre-injury employment by checking the appropriate box for each work activity. If you are unsure of what a specific task is, please ask the receptionist for the "Sheet of Definitions."

TASK	NEVER	OCCASIONAL	FREQUENT	CONSTANT
STANDING	☐	☐	☐	☐
SITTING	☐	☐	☐	☐
WALKING	☐	☐	☐	☐
LIFTING	☐	☐	☐	☐
CARRYING	☐	☐	☐	☐
PUSHING	☐	☐	☐	☐
PULLING	☐	☐	☐	☐
CLIMBING	☐	☐	☐	☐
BALANCING	☐	☐	☐	☐
STOOPING	☐	☐	☐	☐
KNEELING	☐	☐	☐	☐
CROUCHING	☐	☐	☐	☐
CRAWLING	☐	☐	☐	☐
REACHING	☐	☐	☐	☐
HANDLING	☐	☐	☐	☐
FINGERING	☐	☐	☐	☐

- If your job required lifting, what was the heaviest weight you were required to lift? _____pounds
- How long were you employed at your current job prior to your injury? _____ days /months/years
- Do you feel capable of returning to your original job? ___YES ___NO ___ Maybe
- Do you feel capable of returning to some other type of work? ___YES ___ NO ___ Maybe
- Are you working currently? ___ NO ___ YES at the original job ___ YES at a new job
- If you are not working, and don't plan to return to work, have you filed for Disability ___ YES ___ NO