

# Watervliet Housing Authority

2400 Second Avenue  
 Watervliet, NY 12189  
[Office@WatervlietHousing.org](mailto:Office@WatervlietHousing.org)

Telephone: (518) 273-4717  
 Fax: (518) 273-4730

## Physical Capabilities Worksheet

Please complete this form after your examination of the patient. Indicate the patient's restrictions, if any, including modified hours, duties, environmental factors, and any other information pertinent to this patient's healthy recovery.

Patient's Name: \_\_\_\_\_

Medical Diagnosis: \_\_\_\_\_

In an eight-hour day, how many hours can this resident:

<b>Sit:</b>	1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ]	<b>Continuously</b> [ ]	<b>With Rests</b> [ ]
<b>Stand:</b>	1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ]	<b>Continuously</b> [ ]	<b>With Rests</b> [ ]
<b>Walk:</b>	1 [ ] 2 [ ] 3 [ ] 4 [ ] 5 [ ] 6 [ ] 7 [ ] 8 [ ]	<b>Continuously</b> [ ]	<b>With Rests</b> [ ]

In a given day, how many total hours can this resident volunteer? \_\_\_\_\_

### Upper Extremities

Which hand is dominant? Right [ ] Left [ ]  
 Can the patient perform these repetitive actions?

	<b>Yes</b>	<b>No</b>
<b>Simple Grasping :</b>	R [ ] L [ ]	R [ ] L [ ]
<b>Pushing/Pulling:</b>	R [ ] L [ ]	R [ ] L [ ]
<b>Fine Manipulation:</b>	R [ ] L [ ]	R [ ] L [ ]

### Lower Extremities

Can the patient perform repetitive actions to operate foot controls or motor vehicles?

	<b>Yes</b>	<b>No</b>	<b>Simultaneous</b>
R [ ] L [ ]	R [ ] L [ ]		Yes [ ] No [ ]

### Indicate the extent to which the patient can perform the following:

(N = Never, O = Occasionally, F = Frequently, C = Continuously)

<b>Lifting/Carrying</b>	N	O	F	C	<b>Activity</b>	N	O	F	C
<10lbs.					Bend				
11 – 20lbs.					Squat				
21 – 40lbs.					Kneel				
41 – 60lbs.					Twist/Turn				
61 – 100lbs.					Climb				
<b>Pushing/Pulling</b>					Crawl				
<25lbs.					Reach Above Head				
26-50lbs.					Type/Keyboard				
50-75lbs.					<b>Driving</b>				
76-99lbs.					Automatic				
100+lbs.					Standard				

Comments:

Physician Name: \_\_\_\_\_ Date: \_\_\_\_\_

Physician Signature: \_\_\_\_\_ Physician Telephone: \_\_\_\_\_

**Please Fax this form to:**  
 Mary Clinton  
 Watervliet Housing Authority  
 Fax: (518) 273-4730