OMB Approved No. 2900-XXXX
Respondent Burden: 45 minutes

Department of Veterans Affairs

BACK (THORACOLUMBAR SPINE) CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING THIS FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

NOTE TO PHYSICIAN - The veteran has applied to the Department of Veterans Affairs (VA) for disability benefits. Please complete this questionnaire, which VA needs for review of the veteran's application.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN HAVE A THORACOLUMBAR SPINE *(back)* CONDITION?

☐ YES ☐ NO *(If "No," complete Item 1B)* *(If "Yes," complete Item 1C)*

1B. PROVIDE RATIONALE *(e.g., veteran does not currently have any known thoracolumbar spine (back) condition(s))*

1C. PROVIDE DIAGNOSES THAT PERTAIN TO THORACOLUMBAR SPINE *(back)* CONDITION(S)

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1D. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO THORACOLUMBAR SPINE (back) CONDITIONS, LIST USING ABOVE FORMAT

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S THORACOLUMBAR SPINE *(back)* CONDITION *(brief summary)*

2B. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE THORACOLUMBAR SPINE *(back)*?

☐ YES ☐ NO *(If "Yes," document the veteran's description of the impact of flare-ups in his or her own words)*

SECTION III - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS

3. MEASURE ROM WITH A GONIOMETER, ROUNDING EACH MEASUREMENT TO THE NEAREST 5 DEGREES. REPORT INITIAL MEASUREMENTS BELOW.

NOTE: Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use testing must be included in all exams. The VA has determined that 3 repetitions of ROM can serve as a representative test of the effect of repetitive use. After the initial measurement, reassess ROM after 3 repetitions. Report post-test measurements in Section IV.

A. CHECK BOX AT WHICH FORWARD FLEXION ENDS (normal endpoint is 90)

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45
☐ 50 ☐ 55 ☐ 60 ☐ 65 ☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 or greater

B. CHECK BOX AT WHICH EXTENSION ENDS (normal endpoint is 30)

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

C. CHECK BOX AT WHICH RIGHT LATERAL FLEXION ENDS (normal endpoint is 30)

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

D. CHECK BOX AT WHICH LEFT LATERAL FLEXION ENDS (normal endpoint is 30)

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

E. CHECK BOX AT WHICH RIGHT LATERAL ROTATION ENDS (normal endpoint is 30)

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

F. CHECK BOX AT WHICH LEFT LATERAL ROTATION ENDS (normal endpoint is 30)

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

G. If ROM for this veteran does not conform to the normal range of motion identified above but is normal for this veteran (for reasons other than a back condition, such as age, body habitus, neurologic disease), explain: _____

_____

_____

SECTION IV - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING

4A. IS VETERAN ABLE TO PERFORM REPETITIVE-USE TESTING WITH 3 REPETITIONS?

☐ YES ☐ NO *(If unable, provide reason):* _____

(If veteran is unable to perform repetitive-use testing, skip to Section V)

(If veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions)

B. CHECK BOX AT WHICH POST-TEST FORWARD FLEXION ENDS

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐

☐ 50 ☐ 55 ☐ 60 ☐ 65 ☐ 70 ☐ 75 ☐ 80 ☐ 85 ☐ 90 or greater

C. CHECK BOX AT WHICH POST-TEST EXTENSION ENDS

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

D. CHECK BOX AT WHICH POST-TEST RIGHT LATERAL FLEXION ENDS

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

E. CHECK BOX AT WHICH POST-TEST LEFT LATERAL FLEXION ENDS:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

F. CHECK BOX AT WHICH POST- TEST RIGHT LATERAL ROTATION ENDS:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

G. CHECK BOX AT WHICH POST-TEST LEFT LATERAL ROTATION ENDS:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

SECTION V - FUNCTIONAL LOSS

NOTE: The following section addresses reasons for functional loss, if present, and additional loss of ROM after repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance.

5A. DOES THE VETERAN HAVE ADDITIONAL LIMITATION IN ROM OF THE THORACOLUMBAR SPINE *(back)* FOLLOWING REPETITIVE-USE TESTING?

☐ YES ☐ NO

5B. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS AND/OR FUNCTIONAL IMPAIRMENT OF THE THORACOLUMBAR SPINE *(back)*?

☐ YES ☐ NO

5C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT AND/OR ADDITIONAL LIMITATION OF ROM OF THE THORACOLUMBAR SPINE *(back)* AFTER REPETITIVE USE, INDICATE THE CONTRIBUTING FACTORS OF DISABILITY BELOW *(Check all that apply)*

No.	ITEM	YES	NO
1	Less movement than normal	☐	☐
2	More movement than normal	☐	☐
3	Weakened movement	☐	☐
4	Excess fatigability	☐	☐
5	Incoordination, impaired ability to execute skilled movements smoothly	☐	☐
6	Pain on movement	☐	☐
7	Swelling	☐	☐
8	Deformity	☐	☐
9	Atrophy of disuse	☐	☐
10	Instability of station	☐	☐
11	Disturbance of locomotion	☐	☐
12	Interference with sitting, standing and/or weight-bearing	☐	☐

SECTION VI - PAIN (PAINFUL MOTION, PAIN ON PALPATION, MUSCLE SPASM, GAIT)

6A. IS THERE OBJECTIVE EVIDENCE OF PAINFUL MOTION FOR THE THORACOLUMBAR SPINE *(back)*?

☐ YES ☐ NO

6B. DOES THE VETERAN HAVE LOCALIZED TENDERNESS OR PAIN TO PALPATION FOR JOINTS/SOFT TISSUE OF THE THORACOLUMBAR SPINE *(back)*?

☐ YES ☐ NO

6C. DOES THE VETERAN HAVE GUARDING OR MUSCLE SPASM OF THE THORACOLUMBAR SPINE *(back)*?

☐ YES ☐ NO *(If "Yes," is it severe enough to result in): (Check all that apply)*

- ☐ Abnormal gait
- ☐ Abnormal spinal contour, such as scoliosis, reversed lordosis, or abnormal kyphosis
- ☐ Guarding or muscle spasm do not result in abnormal gait or spinal contour

SECTION VII - RADICULOPATHY HISTORY AND NEUROLOGIC EXAM

7A. DOES THE VETERAN NOW HAVE OR HAS THE VETERAN HAD RADICULOPATHY?

☐ YES ☐ NO *(If "No," skip to Section VIII)*

7B. DOES THE VETERAN CURRENTLY HAVE RADICULAR PAIN OR ANY OTHER SIGNS AND/OR SYMPTOMS DUE TO RADICULOPATHY?

☐ YES ☐ NO *(If "Yes," indicate symptoms, location, and degree of severity): (Check all that apply)*

CONSTANT PAIN (may be excruciating at times)

Right lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Left lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe

Intermittent PAIN (usually dull)

Right lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Left lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe

PARESTHESIAS AND/OR DYSESTHESIAS

Right lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Left lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe

NUMBNESS

Right lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Left lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe

7C. ARE THERE ANY OTHER SIGNS OR SYMPTOMS OF RADICULOPATHY?

☐ YES ☐ NO *(If "Yes," describe):* _____

_____

_____

_____

_____

_____

_____

7D. STRENGTH EXAM - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

0/5 No muscle movement
1/5 Visible muscle movement, but no joint movement
2/5 No movement against gravity
3/5 No movement against resistance
4/5 Less than normal strength
5/5 Normal strength

HIP FLEXION (L2)

Right	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Left	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5

KNEE EXTENSION (L3):

Right	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Left	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5

ANKLE PLANTAR FLEXION (S1):

Right	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Left	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5

ANKLE DORSIFLEXION (L4):

Right	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Left	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5

GREAT TOE EXTENSION (L5):

Right	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Left	☐ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5

7E. REFLEX EXAM - RATE DEEP TENDON REFLEXES (DTRs) ACCORDING TO THE FOLLOWING SCALE:

0 Absent
1+ Decreased
2+ Normal
3+ Increased without sustained clonus
4+ Increased with clonus

KNEE:

Right	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Left	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+

ANKLE:

Right	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+
Left	☐ 0	☐ 1+	☐ 2+	☐ 3+	☐ 4+

SECTION VII - RADICULOPATHY HISTORY AND NEUROLOGIC EXAM *(Continued)*

7F. SENSORY EXAM - PROVIDE RESULTS FOR SENSATION TO LIGHT TOUCH *(dermatomes)* TESTING

Other sensory findings, if any: _____

L2 (Upper anterior thigh)	Right	☐ Normal	☐ Decreased	☐ Absent	
	Left	☐ Normal	☐ Decreased	☐ Absent	
L3 (Lower anterior thigh)	Right	☐ Normal	☐ Decreased	☐ Absent	
	Left	☐ Normal	☐ Decreased	☐ Absent	
L4 (Anterior leg, medial calf)	Right	☐ Normal	☐ Decreased	☐ Absent	
	Left	☐ Normal	☐ Decreased	☐ Absent	
L5 (Lateral leg and calf, dorsum medial foot)	Right	☐ Normal	☐ Decreased	☐ Absent	
	Left	☐ Normal	☐ Decreased	☐ Absent	
S1 (Posterior leg and calf, dorsum lateral foot)	Right	☐ Normal	☐ Decreased	☐ Absent	
	Left	☐ Normal	☐ Decreased	☐ Absent	

7G. STRAIGHT LEG RAISING TESTING - This test can be performed with the veteran seated or supine. Raise each straightened leg until pain begins, typically at 30-70 degrees of elevation. The test is positive if the pain radiates below the knee, not merely in the back or hamstrings. Pain is often increased on dorsiflexion of the foot, and relieved by knee flexion. A positive test suggests radiculopathy, often due to disc herniation.

Right ☐ Negative ☐ Positive ☐ Unable to perform

Left ☐ Negative ☐ Positive ☐ Unable to perform

7H. DOES THE VETERAN HAVE MUSCLE ATROPHY?

☐ YES ☐ NO (If muscle atrophy is present, indicate location: _____

and provide difference measured in cm between normal and atrophied side, measured at maximum muscle bulk: _____ cm

7I. IF THE VETERAN HAS RADICULOPATHY, INDICATE NERVE ROOTS INVOLVED: *(Check all that apply)*

☐ INVOLVEMENT OF L2/L3/L4 NERVE ROOTS (femoral nerve, if checked, indicate: ☐ Right ☐ Left ☐ Both)

☐ INVOLVEMENT OF L4/L5/S1/S2/S3 NERVE ROOTS (sciatic nerve, if checked, indicate: ☐ Right ☐ Left ☐ Both)

☐ OTHER NERVES (specify nerve and side(s) affected: _____

7J. IF THE VETERAN HAS RADICULOPATHY, INDICATE SEVERITY AND SIDE AFFECTED:
(**NOTE**: For VA purposes, when the involvement is wholly sensory, the evaluation should be for the mild, or at most, the moderate degree)

Right ☐ Not affected ☐ Mild ☐ Moderate ☐ Severe

Left ☐ Not affected ☐ Mild ☐ Moderate ☐ Severe

SECTION VIII - OTHER NEUROLOGIC ABNORMALITIES

8. DOES THE VETERAN HAVE ANY OTHER NEUROLOGIC ABNORMALITIES OR FINDINGS RELATED TO A THORACOLUMBAR SPINE *(back)* CONDITION *(such as bowel or bladder problems/pathologic reflexes)*?

(If "Yes," describe condition and how it is related: _____

☐ YES ☐ NO Also if there are neurological abnormalities other than radiculopathy, also complete the appropriate questionnaire for each condition identified)

SECTION IX - INTERVERTEBRAL DISC SYNDROME (IVDS) AND INCAPACITATING EPISODES

9. DOES THE VETERAN HAVE IVDS OF THE THORACOLUMBAR SPINE?

☐ YES ☐ NO

(If "Yes," has the IVDS caused any incapacitating episodes over the past 12 months?)

Note: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require prescribed bed rest and treatment by a physician

☐ YES ☐ NO *(If "Yes," provide the total duration over the past 12 months)*

- ☐ LESS THAN 1 WEEK
- ☐ AT LEAST 1 WEEK BUT LESS THAN 2 WEEKS
- ☐ LESS THAN 2 WEEKS
- ☐ AT LEAST 2 WEEKS BUT LESS THAN 4 WEEKS
- ☐ AT LEAST 4 WEEKS BUT LESS THAN 6 WEEKS
- ☐ AT LEAST 6 WEEKS

SECTION X - ASSISTIVE DEVICES AND REMAINING FUNCTION OF THE EXTREMITIES

10A. DOES THE VETERAN USE ANY ASSISTIVE DEVICE(S) AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

☐ YES ☐ NO *(If "Yes," identify assistive device(s) used (check all that apply and indicate frequency))*

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Brace(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutch(es)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

10B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

10C. DUE TO A THORACOLUMBAR SPINE (back) CONDITION, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTION REMAINS OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? *(Functions of the upper extremity include grasping, manipulation, etc.; functions of the lower extremity include balance and propulsion, etc.)*

☐ YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROSTHESIS WOULD EQUALLY SERVE THE VETERAN

☐ NO *(If "Yes," indicate extremity(ies) (check all extremities for which this applies)*

☐ Right lower ☐ Left lower ☐ Bilateral lower

SECTION XI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

11. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

☐ YES ☐ NO *(If "Yes," describe (brief summary))* _____

SECTION XII - DIAGNOSTIC TESTING

NOTE: The diagnosis of arthritis must be confirmed by imaging studies. Once arthritis has been documented, no further imaging studies are indicated, even if arthritis has worsened.

Imaging studies are not required to make the diagnosis of IVDS; Electromyography (EMG) studies are rarely required to diagnose radiculopathy in the appropriate clinical setting.

For purposes of this examination, the diagnosis of IVDS and/or radiculopathy can be made by a history of characteristic radiating pain and/or sensory changes in the arms, and objective clinical findings, which may include the asymmetrical loss or decrease of reflexes, decreased strength and/or abnormal sensation.

12A. HAVE THE IMAGING STUDIES OF THE THORACOLUMBAR SPINE BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

(If "Yes," is arthritis documented?)

☐ YES ☐ NO

12B. DOES THE VETERAN HAVE A VERTEBRAL FRACTURE?

☐ YES ☐ NO

(If "Yes," provide percent of loss of vertebral body): _____

12C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO

(If "Yes," provide type of test or procedure, date and results (brief summary)): _____

SECTION XIII - FUNCTIONAL IMPACT AND REMARKS

13. DOES THE VETERAN'S THORACOLUMBAR SPINE (back) CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe impact of the veteran's thoracolumbar spine (back) condition(s), providing one or more examples)*

14. REMARKS *(If any)*

SECTION XIV - PHYSICIAN'S CERTIFICATION AND SIGNATURE

CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.

15A. PHYSICIAN'S SIGNATURE	15B. PHYSICIAN'S PRINTED NAME	15C. DATE SIGNED

15D. PHYSICIAN'S PHONE NUMBER	15E. PHYSICIAN'S MEDICAL LICENSE NUMBER	15F. PHYSICIAN'S ADDRESS

NOTE - VA may obtain additional medical information, including an examination, if necessary to complete VA's review of the veteran's application.

IMPORTANT - Physician please fax the completed form to _____

(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at www.vba.va.gov/disabilityexams or obtained by calling 1-800-827-1000.

PRIVACY ACT NOTICE: VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of low in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN : We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 45 minutes to review the instructions, find the information, and complete a form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.reginfo.gov/public/do/PRAMain. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.