OMB Approved No. 2900-0776
Respondent Burden: 30 minutes

Department of Veterans Affairs

WRIST 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 FORM.

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

NOTE TO PHYSICIAN - Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the veteran's claim.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER HAD A WRIST CONDITION?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO WRIST CONDITIONS:

Diagnosis # 1	ICD code -	Date of diagnosis	Side affected ☐ Right ☐ Left ☐ Both
Diagnosis # 2	ICD code -	Date of diagnosis	Side affected ☐ Right ☐ Left ☐ Both
Diagnosis # 3	ICD code -	Date of diagnosis	Side affected ☐ Right ☐ Left ☐ Both

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO WRIST CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

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

2B. DOMINANT HAND

☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

SECTION III - FLARE-UPS

3. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE WRIST?

☐ YES ☐ NO

IF YES, DOCUMENT THE VETERANS'S DESCRIPTION OF THE IMPACT OF FLARE-UPS IN HIS OR HER OWN WORDS:

SECTION IV - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS

4. MEASURE ROM WITH A GONIOMETER, ROUNDING EACH MEASUREMENT TO THE NEAREST 5 DEGREES. DURING THE MEASUREMENTS, DOCUMENT THE POINT AT WHICH PAINFUL MOTION BEGINS, EVIDENCED BY VISIBLE BEHAVIOR SUCH AS FACIAL EXPRESSION, WINCING, ETC. REPORT INITIAL MEASUREMENTS BELOW:

FOLLOWING THE INITIAL ASSESSMENT OF ROM, PERFORM REPETITIVE USE TESTING. FOR VA PURPOSES, REPETITIVE USE TESTING MUST BE INCLUDED IN ALL JOINT EXAMS. THE VA HAS DETERMINED THAT 3 REPETITIONS OF ROM (AT A MINIMUM) CAN SERCE 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 5.

A. Right wrist palmar flexion

Select where palmar flexion ends *(endpoint of palmar flexion 80 degrees)*:

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

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50
☐ 55 ☐ 60 ☐ 65 ☐ 70 or greater

B. Right wrist dorsiflexion *(extension)*

Select where dorsiflexion *(extension)* ends *(endpoint of dorsiflexion (extension) 70 degrees)*:

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

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50
☐ 55 ☐ 60 ☐ 65 ☐ 70 or greater

SECTION IV - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS *(Continued)*

C. Left wrist palmar flexion

Select where palmar flexion ends *(endpoint of palmar flexion 80 degrees)*:

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

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50
☐ 55 ☐ 60 ☐ 65 ☐ 70 or greater

D. Left wrist dorsiflexion *(extension)*

Select where dorsiflexion *(extension)* ends *(endpoint of dorsiflexion (extension) 70 degrees)*:

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

Select where objective evidence of painful motion begins:

☐ No objective evidence of painful motion
☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 ☐ 50
☐ 55 ☐ 60 ☐ 65 ☐ 70 or greater

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

SECTION V - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING

5A. 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 6.

IF VETERAN IS ABLE TO PERFORM REPETITIV-USE TESTING, MEASURE AND REPORT ROM AFTER A MINIMUM OF 3 REPETITIONS.

5B. RIGHT WRIST POST-TEST ROM

Select where palmar flexion ends:

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

Select where dorsiflexion (extension) ends:

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

5C. LEFT WRIST POST-TEST ROM

Select where palmar flexion ends:

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

Select where dorsiflexion (extension) ends:

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

SECTION VI - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION IN ROM

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.

6A. DOES THE VETERAN HAVE ADDITIONAL LIMITATION IN ROM OF THE WRIST FOLLOWING REPETITIVE-USE TESTING?

☐ YES ☐ NO

6B. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS AND/OR FUNCTIONAL IMPAIRMENT OF THE WRIST?

☐ YES ☐ NO

SECTION VI - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION IN ROM *(Continued)*

6C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT AND/OR ADDITIONAL LIMITATION OF ROM OF THE WRIST AFTER REPETITIVE USE, INDICATE THE CONTRIBUTING FACTORS OF DISABILITY BELOW *(Check all that apply and indicate side affected)*:

- ☐ NO FUNCTIONAL LOSS FOR RIGHT UPPER EXTREMITY
- ☐ NO FUNCTIONAL LOSS FOR LEFT UPPER EXTREMITY

☐ LESS MOVEMENT THAN NORMAL	☐ Right	☐ Left	☐ Both
☐ MORE MOVEMENT THAN NORMAL	☐ Right	☐ Left	☐ Both
☐ WEAKENED MOVEMENT	☐ Right	☐ Left	☐ Both
☐ EXCESS FATIGABILITY	☐ Right	☐ Left	☐ Both
☐ INCOORDINATION (IMPAIRED ABILITY TO EXECUTE SKILLED MOVEMENTS SMOOTHLY)	☐ Right	☐ Left	☐ Both
☐ PAIN ON MOVEMENT	☐ Right	☐ Left	☐ Both
☐ SWELLING	☐ Right	☐ Left	☐ Both
☐ DEFORMITY	☐ Right	☐ Left	☐ Both
☐ ATROPHY OF DISUSE	☐ Right	☐ Left	☐ Both

SECTION VII - PAIN (PAIN ON PALPATION)

7. DOES THE VETERAN HAVE LOCALIZED TENDERNESS OR PAIN ON PALPATION FOR JOINTS/SOFT TISSUE OF EITHER WRIST?

☐ YES ☐ NO

IF YES, SIDE AFFECTED:

☐ Right ☐ Left ☐ Both

SECTION VIII- MUSCLE STRENGTH TESTING

8. RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

0/5 No muscle movement

1/5 Palpable or visible muscle movement, but no joint movement

2/5 Active movement with gravity eliminated

3/5 Active movement against gravity

4/5 Active movement against some resistence

5/5 Normal strength

Wrist flexion:	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
Wrist extension:	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

SECTION IX- ANKYLOSIS

9. DOES THE VETERAN HAVE ANKYLOSIS OF EITHER WRIST JOINT?

☐ YES ☐ NO

IF YES, INDICATE SEVERITY AND SIDE AFFECTED:

Extremely unfavorable	☐ Right	☐ Left	☐ Both
Unfavorable, with ulnar or radial deviation	☐ Right	☐ Left	☐ Both
Unfavorable, in any degree of palmar flexion	☐ Right	☐ Left	☐ Both
Any other position, except favorable	☐ Right	☐ Left	☐ Both
Favorable in 20 degree to 30 degree dorsiflexion	☐ Right	☐ Left	☐ Both

SECTION X- JOINT REPLACEMENT AND/OR OTHER SURGICAL PROCEDURES

10A. HAS THE VETERAN HAD A TOTAL WRIST JOINT REPLACEMENT?

☐ YES ☐ NO

IF YES, INDICATE SIDE AND SEVERITY OF RESIDUALS:

☐ Right wrist

(Date of surgery): _____

Residuals

- ☐ None
- ☐ Intermediate degrees of residual weakness, pain and/or limitation of motion
- ☐ Chronic residuals consisting of severe painful motion and/or weakness
- ☐ Other, describe: _____

SECTION X- JOINT REPLACEMENT AND/OR OTHER SURGICAL PROCEDURES *(CONTINUED)*

10A. HAS THE VETERAN HAD A TOTAL WRIST JOINT REPLACEMENT? (Continued)

☐ Left wrist

(Date of surgery): _____

Residuals

☐ None

☐ Intermediate degrees of residual weakness, pain and/or limitation of motion

☐ Chronic residuals consisting of severe painful motion and/or weakness

☐ Other, describe: _____

10B. HAS THE VETERAN HAD ARTHROSCOPIC OR OTHER WRIST SURGERY?

☐ YES ☐ NO

IF YES, INDICATE SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

(Date and type of surgery): _____

10C. DOES THE VETERAN HAVE ANY RESIDUAL SIGNS AND/OR SYMPTOMS DUE TO ARTHROSCOPIC OR OTHER WRIST SURGERY?

☐ YES ☐ NO

IF YES, INDICATE SIDE AFFECTED: ☐ Right ☐ Left ☐ Both

IF YES, DESCRIBE RESIDUALS: _____

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

11A. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE SECTION I, DIAGNOSIS?

☐ YES ☐ NO

IF YES, ARE ANY OF THE SCARS PAINFUL AND/OR UNSTABLE, OR IS THE TOTAL AREA OF ALL RELATED SCARS GREATER THAN 39 SQUARE CM (6 SQUARE INCHES)?

☐ YES ☐ NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT DISABILITY BENEFITS QUESTIONNAIRE.

11B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO

IF YES, DESCRIBE *(brief summary)*:

SECTION XII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

12. DUE TO THE VETERAN'S WRIST CONDITIONS, 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.)*

☐ 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 upper ☐ Left upper

FOR EACH CHECKED EXTREMITY, DESCRIBE LOSS OF EFFECTIVE FUNCTION, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION AND PROVIDE SPECIFIC EXAMPLES (BRIEF SUMMARY):

SECTION XIII- DIAGNOSTIC TESTING

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

13A. HAVE IMAGING STUDIES OF THE WRIST BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, IS DEGENERATIVE OR TRAUMATIC ARTHRITIS DOCUMENTED?

☐ YES ☐ NO

IF YES, INDICATE WRIST:

☐ Right ☐ Left ☐ Both

SECTION XIII- DIAGNOSTIC TESTING *(Continued)*

13B. 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 XIV FUNCTIONAL IMPACT

14. DOES THE VETERAN'S WRIST CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

IF YES, DESCRIBE THE IMPACT OF EACH OF THE VETERAN'S WRIST CONDITIONS, PROVIDING ONE OR MORE EXAMPLES:

SECTION XV REMARKS

15. REMARKS (If any)

SECTION XVI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

16A. PHYSICIAN'S SIGNATURE	16B. PHYSICIAN'S PRINTED NAME	16C. DATE SIGNED

16D. PHYSICIAN'S PHONE NUMBER AND FAX NUMBER	16E. PHYSICIAN'S MEDICAL LICENSE NUMBER	16F. PHYSICIAN'S ADDRESS

NOTE - VA may request additional medical information, including additional examinations, 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, 58/VA21/22/28, 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 law 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 30 minutes to review the instructions, find the information, and complete the 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.