



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 FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
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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 BEEN DIAGNOSED WITH A THORACOLUMBAR SPINE (*back*) CONDITION?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO THORACOLUMBAR SPINE (*back*) CONDITIONS:

Diagnosis # 1 -	ICD code -	Date of diagnosis -
Diagnosis # 2 -	ICD code -	Date of diagnosis -
Diagnosis # 3 -	ICD code-	Date of diagnosis -

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

SECTION II - MEDICAL HISTORY

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

SECTION III - FLARE-UPS

3. 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 IV - INITIAL RANGE OF MOTION (ROM) MEASUREMENT

4. MEASURE ROM WITH A GONIOMETER, ROUNDING EACH MEASUREMENT TO THE NEAREST 5 DEGREES. DURING THE MEASUREMENTS, OBSERVE THE POINT AT WHICH PAINFUL MOTION BEGINS, EVIDENCED BY VISIBLE BEHAVIOR SUCH AS FACIAL EXPRESSION, WINCING, ETC. 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 (at minimum) 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 5.

A. SELECT WHERE 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

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 75 80 85 90 or greater

B. SELECT WHERE EXTENSION ENDS (*normal endpoint is 30*):

0 5 10 15 20 25 30 or greater

SELECT WHERE OBJECTIVE EVIDENCE OF PAINFUL MOTION BEGINS:

No objective evidence of painful motion
 0 5 10 15 20 25 30 or greater

C. SELECT WHERE RIGHT LATERAL FLEXION ENDS (*normal endpoint is 30*):

0 5 10 15 20 25 30 or greater

SELECT WHERE OBJECTIVE EVIDENCE OF PAINFUL MOTION BEGINS:

No objective evidence of painful motion
 0 5 10 15 20 25 30 or greater

SECTION IV - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS (continued)

D. SELECT WHERE LEFT LATERAL FLEXION ENDS (*normal endpoint is 30*):

0 5 10 15 20 25 30 or greater

SELECT WHERE OBJECTIVE EVIDENCE OF PAINFUL MOTION BEGINS:

No objective evidence of painful motion

0 5 10 15 20 25 30 or greater

E. SELECT WHERE RIGHT LATERAL ROTATION ENDS (*normal endpoint is 30*):

0 5 10 15 20 25 30 or greater

SELECT WHERE OBJECTIVE EVIDENCE OF PAINFUL MOTION BEGINS:

No objective evidence of painful motion

0 5 10 15 20 25 30 or greater

F. SELECT WHERE LEFT LATERAL ROTATION ENDS (*normal endpoint is 30*):

0 5 10 15 20 25 30 or greater

SELECT WHERE OBJECTIVE EVIDENCE OF PAINFUL MOTION BEGINS:

No objective evidence of painful motion

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 V - ROM MEASUREMENT AFTER REPETITIVE-USE TESTING

5A. IS THE 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 REPETITIVE-USE TESTING, MEASURE AND REPORT ROM AFTER A MINIMUM OF 3 REPETITIONS.

B. SELECT WHERE POST-TEST FORWARD FLEXION ENDS:

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

C. SELECT WHERE POST-TEST EXTENSION ENDS:

0 5 10 15 20 25 30 or greater

D. SELECT WHERE POST-TEST RIGHT LATERAL FLEXION ENDS:

0 5 10 15 20 25 30 or greater

E. SELECT WHERE POST-TEST LEFT LATERAL FLEXION ENDS:

0 5 10 15 20 25 30 or greater

F. SELECT WHERE POST-TEST RIGHT LATERAL ROTATION ENDS:

0 5 10 15 20 25 30 or greater

G. SELECT WHERE POST-TEST LEFT LATERAL ROTATION ENDS:

0 5 10 15 20 25 30 or greater

SECTION VI - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION IN ROM

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.

6A. DOES THE VETERAN HAVE ADDITIONAL LIMITATION IN ROM OF THE THORACOLUMBAR SPINE (*back*) FOLLOWING REPETITIVE-USE TESTING?

YES NO

6B. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS AND/OR FUNCTIONAL IMPAIRMENT OF THE THORACOLUMBAR SPINE (*back*)?

YES NO

6C. 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:

- Less movement than normal
- More movement than normal
- Weakened movement
- Excess fatigability
- Incoordination, impaired ability to execute skilled movements smoothly
- Pain on movement
- Swelling
- Deformity
- Atrophy of disuse
- Instability of station
- Disturbance of locomotion
- Interference with sitting, standing and/or weight-bearing
- Other, describe: _____

SECTION VII - PAIN AND MUSCLE SPASM (pain on palpation, effect of muscle spasm on gait)

7A. DOES THE VETERAN HAVE LOCALIZED TENDERNESS OR PAIN TO PALPATION FOR JOINTS AND/OR SOFT TISSUE OF THE THORACOLUMBAR SPINE (back)?

YES NO IF YES, DESCRIBE:

7B. 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 does not result in abnormal gait or spinal contour

SECTION VIII - MUSCLE STRENGTH TESTING

8A. RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

- 0/5 No muscle movement
- 1/5 Palpable or visible muscle contraction, but no joint movement
- 2/5 Active movement with gravity eliminated
- 3/5 Active movement against gravity
- 4/5 Active movement against some resistance
- 5/5 Normal strength

All normal

Hip 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

Knee 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

Ankle plantar 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

Ankle dorsiflexion: 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: 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

8B. DOES THE VETERAN HAVE MUSCLE ATROPHY?

YES NO

IF MUSCLE ATROPHY IS PRESENT, INDICATE LOCATION: _____

PROVIDE MEASUREMENTS IN CENTIMETERS OF NORMAL SIDE AND ATROPHIED SIDE, MEASURED AT MAXIMUM MUSCLE BULK:

NORMAL SIDE: _____ CM ATROPHIED SIDE: _____ CM

SECTION IX - REFLEX EXAM

9. RATE DEEP TENDON REFLEXES (DTRs) ACCORDING TO THE FOLLOWING SCALE:

- 0 Absent
- 1+ Hypoactive
- 2+ Normal
- 3+ Hyperactive without clonus
- 4+ Hyperactive with clonus

All normal

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 X - SENSORY EXAM

10. PROVIDE RESULTS FOR SENSATION TO LIGHT TOUCH (*dermatomes*) TESTING:

All normal

Upper anterior thigh (L2):	Right	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Thigh/knee (L3/4):	Right	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Lower leg/ankle (L4/L5/S1):	Right	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Foot/toes (L5):	Right	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent

Other sensory findings, if any: _____

SECTION XI - STRAIGHT LEG RAISING TEST

(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).

11. PROVIDE STRAIGHT LEG RAISING TEST RESULTS:

Right: Negative Positive Unable to perform
 Left: Negative Positive Unable to perform

SECTION XII - RADICULOPATHY

12A. DOES THE VETERAN HAVE RADICULAR PAIN OR ANY OTHER SIGNS OR SYMPTOMS DUE TO RADICULOPATHY?

YES NO IF YES, COMPLETE THE FOLLOWING SECTION:

12B. INDICATE SYMPTOMS' LOCATION AND 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

12C. DOES THE VETERAN HAVE ANY OTHER SIGNS OR SYMPTOMS OF RADICULOPATHY?

YES NO

IF YES, DESCRIBE:

12D. 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*): _____

12E. INDICATE SEVERITY OF RADICULOPATHY AND SIDE AFFECTED:

Right: Not affected Mild Moderate Severe
 Left: Not affected Mild Moderate Severe

SECTION XIII - OTHER NEUROLOGIC ABNORMALITIES

13. 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*)?

YES NO IF YES, DESCRIBE CONDITION AND HOW IT IS RELATED:

IF THERE ARE NEUROLOGICAL ABNORMALITIES OTHER THAN RADICULOPATHY, ALSO COMPLETE APPROPRIATE QUESTIONNAIRE FOR EACH CONDITION IDENTIFIED.

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

14A. DOES THE VETERAN HAVE IVDS OF THE THORACOLUMBAR SPINE?

YES NO

14B. IF YES, HAS THE VETERAN HAD ANY INCAPACITATING EPISODES OVER THE PAST 12 MONTHS DUE TO IVDS?

YES NO

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.

IF YES, PROVIDE THE TOTAL DURATION OF THE INCAPACITATING EPISODES OVER THE PAST 12 MONTHS:

- Less than 1 week
- At least 1 week but 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 XV - ASSISTIVE DEVICES

15A. 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*):

- | | | | | |
|---------------------------------------|-------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Wheelchair | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Brace(s) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Crutch(es) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Cane(s) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Walker | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Other: _____ | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |

15B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION XVI - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

16. DUE TO 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

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

17A. DOES THE VETERAN HAVE ANY SCARS (*surgical or otherwise*) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

YES NO

IF YES, ARE ANY OF THE SCARS PAINFUL/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)

17B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS?

YES NO IF YES, DESCRIBE (*brief summary*):

SECTION XVIII - DIAGNOSTIC TESTING

NOTE: The diagnosis of arthritis must be confirmed by imaging studies. Once arthritis has been documented, no further imaging studies are required by VA, 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 legs, and objective clinical findings, which may include the asymmetrical loss or decrease of reflexes, decreased strength and/or abnormal sensation.

18A. HAVE THE IMAGING STUDIES OF THE THORACOLUMBAR SPINE BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

YES NO

IF YES, IS ARTHRITIS DOCUMENTED?

YES NO

18B. DOES THE VETERAN HAVE A VERTEBRAL FRACTURE?

YES NO

IF YES, PROVIDE PERCENT OF LOSS OF VERTEBRAL BODY: _____

18C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

YES NO

IF YES, PROVIDE TYPE OF TEST OF PROCEDURE, DATE AND RESULTS (*brief summary*):

SECTION XIX - FUNCTIONAL IMPACT

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

YES NO

IF YES DESCRIBE THE IMPACT OF EACH OF THE VETERAN'S THORACOLUMBAR SPINE (*back*) CONDITIONS PROVIDING ONE OR MORE EXAMPLES

SECTION XX - REMARKS

20. REMARKS (*If any*)

SECTION XXI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

21A. PHYSICIAN'S SIGNATURE

21B. PHYSICIAN'S PRINTED NAME

21C. DATE SIGNED

21D. PHYSICIAN'S PHONE AND FAX NUMBER

21E. PHYSICIAN'S MEDICAL LICENSE NUMBER

21F. 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, 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 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 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.