



NECK (CERVICAL SPINE) 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 NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH A CERVICAL SPINE (*neck*) CONDITION?

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

1B. PROVIDE DIAGNOSES THAT PERTAIN TO CERVICAL SPINE (*neck*) CONDITION(S)

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

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO CERVICAL SPINE (*neck*) CONDITIONS, LIST USING ABOVE FORMAT

SECTION II - MEDICAL HISTORY

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

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

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. 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 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 45 degrees*)

0 5 10 15 20 25 30 35 40 45 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 or greater

B. CHECK BOX AT WHICH EXTENSION ENDS (*normal endpoint is 45 degrees*)

0 5 10 15 20 25 30 35 40 45 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 or greater

C. CHECK BOX AT WHICH RIGHT LATERAL FLEXION ENDS (*normal endpoint is 45 degrees*)

0 5 10 15 20 25 30 35 40 45 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 or greater

D. CHECK BOX AT WHICH LEFT LATERAL FLEXION ENDS (*normal endpoint is 45 degrees*)

0 5 10 15 20 25 30 35 40 45 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 or greater

SECTION III - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS (Continued)

E. CHECK BOX AT WHICH RIGHT LATERAL ROTATION ENDS (*normal endpoint is 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 or greater

F. CHECK BOX AT WHICH LEFT LATERAL ROTATION ENDS (*normal endpoint is 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 or greater

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

SECTION IV - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING

4A. IS A 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 45 or greater

C. CHECK BOX AT WHICH POST-TEST EXTENSION ENDS

- 0 5 10 15 20 25 30 35 40 45 or greater

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

- 0 5 10 15 20 25 30 35 40 45 or greater

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

- 0 5 10 15 20 25 30 35 40 45 or greater

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

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

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

- 0 5 10 15 20 25 30 35 40 45
 50 55 60 65 70 75 80 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 CERVICAL SPINE (*neck*) FOLLOWING REPETITIVE-USE TESTING?

- YES NO

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

- YES NO

5C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT AND/OR ADDITIONAL LIMITATION OF ROM OF THE CERVICAL SPINE (*neck*) AFTER REPETITIVE USE, INDICATE THE CONTRIBUTING FACTORS OF DISABILITY BELOW.

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		
13	Other, describe:		

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

6A. DOES THE VETERAN HAVE LOCALIZED TENDERNESS OR PAIN TO PALPATION FOR JOINTS/SOFT TISSUE OF THE CERVICAL SPINE (neck)?

YES NO

6B. DOES THE VETERAN HAVE GUARDING OR MUSCLE SPASM OF THE CERVICAL SPINE (neck)?

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

- Abnormal gait
- Abnormal spinal contour
- Guarding or muscle spasm is present, but do not result in abnormal gait or spinal contour

SECTION VII - INTERVERTEBRAL DISC SYNDROME (IVDS)

7A. DOES THE VETERAN HAVE IVDS OF THE CERVICAL SPINE?

YES NO (If "Yes," has the Veteran had 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
- At least 2 weeks but less than 4 weeks
- At least 4 weeks but less than 6 weeks
- At least 6 weeks

SECTION VIII - RADICULOPATHY HISTORY AND NEUROLOGIC EXAM

8A. DOES THE VETERAN HAVE RADICULAR PAIN OR ANY OTHER SIGNS 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 upper extremity: None Mild Moderate Severe

Left upper extremity: None Mild Moderate Severe

INTERMITTENT PAIN (usually dull)

Right upper extremity: None Mild Moderate Severe

Left upper extremity: None Mild Moderate Severe

PARESTHESIAS AND/OR DYSESTHESIAS

Right upper extremity: None Mild Moderate Severe

Left upper extremity: None Mild Moderate Severe

NUMBNESS

Right upper extremity: None Mild Moderate Severe

Left upper extremity: None Mild Moderate Severe

8B. DOES THE VETERAN HAVE ANY OTHER SIGNS OR SYMPTOMS OF RADICULOPATHY?

YES NO (If "Yes," describe):

8C. INDICATE NERVE ROOTS INVOLVED: (Check all that apply)

- Involvement of C5/C6 nerve roots (upper radicular group)
- Involvement of C7 nerve roots (middle radicular group)
- Involvement of C8/T1 nerve roots (lower radicular group)

8D. INDICATE SEVERITY OF RADICULOPATHY 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

8E. MUSCLE STRENGTH EXAM - 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

ELBOW FLEXION (C5):

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

ELBOW EXTENSION (C7):

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 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

SECTION VIII - RADICULOPATHY HISTORY AND NEUROLOGIC EXAM (Continued)

WRIST EXTENSION (C6):

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

FINGER FLEXION (C8):

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

FINGER ABDUCTION (T1):

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

8F. REFLEX EXAM - 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

BICEPS:

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

TRICEPS:

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

BRACHIORADIALIS:

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

8G. SENSORY EXAM - PROVIDE RESULTS FOR SENSATION TO LIGHT TOUCH (dermatomes) TESTING

All Normal

(Shoulder area (C5):	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
(Inner/outer forearm)(C6/T1):	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
(Hand/fingers) (C6-8):	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:

8H. DOES THE VETERAN HAVE MUSCLE ATROPHY?

YES NO (If muscle atrophy is present, indicate location: _____ and provide measurements in centimeters of normal side and atrophied side, measured at maximum muscle bulk: Normal side: _____ cm. Atrophied side: _____ cm.

SECTION IX - OTHER NEUROLOGIC ABNORMALITIES

9. DOES THE VETERAN HAVE ANY OTHER NEUROLOGIC ABNORMALITIES RELATED TO A CERVICAL SPINE (neck) CONDITION (such as bowel or bladder problems due to cervical myelopathy)?

YES NO (If "Yes," describe _____).
 Also complete the appropriate questionnaire, if indicated)

SECTION X - INCAPACITATING EPISODES

10. AS A RESULT OF THE CERVICAL SPINE CONDITION HAS THE VETERAN EXPERIENCED INCAPACITATING EPISODES DURING THE PAST 12 MONTHS?

YES NO (If "Yes," indicate the total duration for the 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 or other healthcare provider)

- 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 XI - ASSISTIVE DEVICES AND REMAINING FUNCTION OF THE EXTREMITIES

11A. 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

11B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION

11C. DUE TO A CERVICAL SPINE (neck) 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 upper Left upper Bilateral upper

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

12A. DOES THE VETERAN HAVE ANY SCARS (SURGICAL OR OTHERWISE) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I?

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)*

12B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

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

SECTION XIII - 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.

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

YES NO

(If "Yes," is arthritis (degenerative joint disease) documented?)

YES NO

13B. DOES THE VETERAN HAVE A VERTEBRAL FRACTURE?

YES NO

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

13C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

YES NO

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

SECTION XIV - FUNCTIONAL IMPACT

14. DOES THE VETERAN'S CERVICAL SPINE (neck) CONDITION IMPACT HIS OR HER ABILITY TO WORK?

YES NO *(If "Yes," describe impact of the veteran's cervical spine (neck) condition(s), 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 AND FAX NUMBER	16E. PHYSICIAN'S MEDICAL LICENSE NUMBER	16F. 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 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.