OMB Approved No. 2900-0778
Respondent Burden: 30 Minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

CENTRAL NERVOUS SYSTEM AND NEUROMUSCULAR DISEASES (EXCEPT TRAUMATIC BRAIN INJURY, AMYOTROPHIC LATERAL SCLEROSIS, PARKINSON'S DISEASE, MULTIPLE SCLEROSIS, HEADACHES, TMJ CONDITIONS, EPILEPSY, NARCOLEPSY, PERIPHERAL NEUROPATHY, SLEEP APNEA, CRANIAL NERVE DISORDERS, FIBROMYALGIA, CHRONIC FATIGUE SYNDROME) 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. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A CENTRAL NERVOUS SYSTEM (CNS) CONDITION?

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

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed below. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in the Remarks section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date is determined through record review or reported history.

1B. SELECT THE VETERAN'S CONDITION: *(check all that apply)*

☐ CNS INFECTIONS: ICD code(s): _____ Date of diagnosis: _____
- ☐ Meningitis
  - Specify organism: _____
- ☐ Brain abscess
  - Specify organism: _____
- ☐ HIV
- ☐ Neurosyphilis
- ☐ Lyme disease
- ☐ Encephalitis, epidemic, chronic, including poliomyelitis, anterior (anterior horn cells)
- ☐ Other *(specify)*: _____

☐ VASCULAR DISEASES: ICD code(s): _____ Date of diagnosis: _____
- ☐ Thrombosis, TIA or cerebral infarction
- ☐ Hemorrhage *(specify type)*: _____
- ☐ Cerebral arteriosclerosis
- ☐ Other *(specify)*: _____

☐ HYDROCEPHALUS: ICD code(s): _____ Date of diagnosis: _____
- ☐ Obstructive
- ☐ Communicating
- ☐ Normal pressure (NPH)

☐ BRAIN TUMOR: ICD code(s): _____ Date of diagnosis: _____

☐ SPINAL CORD CONDITIONS: ICD code(s): _____ Date of diagnosis: _____
- ☐ Syringomyelia
- ☐ Myelitis
- ☐ Hematomyelia
- ☐ Spinal Cord Injuries
  - ☐ Radiation injury
  - ☐ Electric or lightning injury
  - ☐ Decompression sickness (DCS)
  - ☐ Other *(specify)*: _____
- ☐ Spinal cord tumor
- ☐ Other *(specify)*: _____

☐ BRAIN STEM CONDITIONS: ICD code(s): _____ Date of diagnosis: _____
- ☐ Bulbar palsy
- ☐ Pseudobulbar palsy
- ☐ Other *(specify)*: _____

SECTION I - DIAGNOSIS *(Continued)*

1B. SELECT THE VETERAN'S CONDITION: *(Continued) (check all that apply)*

☐ MOVEMENT DISORDERS: ICD code(s): _____ Date of diagnosis: _____

- ☐ Athetosis, acquired
- ☐ Myoclonus I
- ☐ Paramyoclonus multiplex *(convulsive state, myoclonic type)*
- ☐ Tic convulsive *(Gilles de la Tourette Syndrome)*
- ☐ Dystonia *(specify type)*: _____
- ☐ Essential tremor
- ☐ Tardive dyskinesia or other neuroleptic induced syndromes
- ☐ Other *(specify)*: _____

☐ NEUROMUSCULAR DISORDERS: ICD code(s): _____ Date of diagnosis: _____

- ☐ Myasthenia gravis
- ☐ Myasthenic syndrome
- ☐ Botulism
- ☐ Hereditary muscular disorders *(specify)*: _____
- ☐ Familial periodic paralysis
- ☐ Myoglobinuria
- ☐ Dermatomyositis or polyomiositis *(specify)*: _____
- ☐ Other *(specify)*: _____

☐ INTOXICATIONS: ICD code(s): _____ Date of diagnosis: _____

- ☐ Heavy metal intoxication *(specify)*: _____
- ☐ Solvents *(specify)*: _____
- ☐ Insecticides, pesticides, others *(specify)*: _____
- ☐ Nerve gas agents
- ☐ Herbicides/defoliants *(specify)*: _____
- ☐ Other *(specify)*: _____

☐ OTHER CENTRAL NERVOUS CONDITION

- ☐ Other diagnosis # 1 _____
  ICD code: _____ Date of diagnosis: _____
- ☐ Other diagnosis # 2 _____
  ICD code: _____ Date of diagnosis: _____

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

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S CENTRAL NERVOUS SYSTEM CONDITION(S) *(Brief summary)* *(Continued on Page 3)*

SECTION II - MEDICAL HISTORY *(Continued)*

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S CENTRAL NERVOUS SYSTEM CONDITION(S) *(Brief summary) (Continued)*

2B. DOES THE VETERAN'S CENTRAL NERVOUS SYSTEM CONDITION (S) REQUIRE CONTINUOUS MEDICATIONS FOR CONTROL?

☐ YES ☐ NO

IF YES, LIST MEDICATIONS USED FOR CENTRAL NERVOUS SYSTEM CONDITIONS:

2C. DOES THE VETERAN HAVE AN INFECTIOUS CONDITION?

☐ YES ☐ NO

IF YES, IS IT ACTIVE?

☐ Yes ☐ No

IF NO, DESCRIBE RESIDUALS IF ANY:

2D. DOMINANT HAND

☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS

3A. DOES THE VETERAN HAVE ANY MUSCLE WEAKNESS IN THE UPPER AND/OR LOWER EXTREMITIES?

☐ YES ☐ NO

IF YES, REPORT UNDER STRENTH TESTING IN SECTION IV, NEUROLOGIC EXAM.

3B. DOES THE VETERAN HAVE ANY PHARYNX AND/OR LARYNX AND/OR SWALLOWING CONDITIONS?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

- ☐ Constant inability to communicate by speech
- ☐ Speech not intelligible or individual is aphonic
- ☐ Paralysis of soft palate with swallowing difficulty *(nasal regurgitation)* and speech impairment
- ☐ Hoarseness
- ☐ Mild swallowing difficulties
- ☐ Moderate swallowing difficulties
- ☐ Severe swallowing difficulties, permitting passage of liquids only
- ☐ Requires feeding tube due to swallowing difficulties
- ☐ Other, *(describe)*: _____

3C. DOES THE VETERAN HAVE ANY RESPIRATORY CONDITIONS *(such as rigidity of the diaphragm, chest wall or laryngeal muscles)*?

☐ YES ☐ NO

IF YES, PROVIDE PFT RESULTS IN SECTION XI, DIAGNOSTIC TESTING.

3D. DOES THE VETERAN HAVE SLEEP DISTURBANCES?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

- ☐ Insomnia
  - ☐ Hypersomnolence and/or daytime "sleep attacks"
  - ☐ Persistent daytime hypersomnolence
  - ☐ Sleep apnea requiring the use of breathing assistance device such as continuous airway pressure (CPAP) machine
- ☐ Sleep apnea causing chronic respiratory failure with carbon dioxide retention or cor pulmonale
- ☐ Sleep apnea requiring tracheostomy

SECTION III - CONDITIONS, SIGNS AND SYMPTOMS *(Continued)*

3E. DOES THE VETERAN HAVE ANY BOWEL FUNCTIONAL IMPAIRMENT?

☐ YES ☐ NO

IF YES, CHECK ALL THAT APPLY:

- ☐ Slight impairment of sphincter control, without leakage
- ☐ Constant slight impairment of sphincter control, or occasional moderate leakage
- ☐ Occasional involuntary bowel movements, necessitating wearing of a pad
- ☐ Extensive leakage and fairly frequent involuntary bowel movements
- ☐ Total loss of bowel sphincter control
- ☐ Chronic constipation
- ☐ Other bowel impairment *(describe)*: _____

3F. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING URINE LEAKAGE?

☐ YES ☐ NO

IF YES, CHECK ONE:

- ☐ Does not require/does not use absorbent material
- ☐ Requires absorbent material that is changed less than 2 times per day
- ☐ Requires absorbent material that is changed 2 to 4 times per day
- ☐ Requires absorbent material that is changed more than 4 times per day

3G. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING SIGNS AND/OR SYMPTOMS OF URINARY FREQUENCY?

☐ YES ☐ NO

IF YES, CHECK ONE DAY TIME AND ONE NIGHT TIME.

- ☐ Daytime voiding interval between 2 and 3 hours
- ☐ Daytime voiding interval between 1 and 2 hours
- ☐ Daytime voiding interval less than 1 hour
- ☐ Nighttime awakening to void 2 times
- ☐ Nighttime awakening to void 3 to 4 times
- ☐ Nighttime awakening to void 5 or more times

3H. DOES THE VETERAN HAVE VOIDING DYSFUNCTION CAUSING FINDINGS, SIGNS AND/OR SYMPTOMS OF OBSTRUCTED VOIDING?

☐ YES ☐ NO

IF YES, CHECK ALL SIGNS AND SYMPTOMS THAT APPLY:

- ☐ Hesitancy *(If checked, is hesitancy marked?)*
  - ☐ Yes ☐ No
- ☐ Slow or weak stream *(If checked, is stream markedly slow or weak?)*
  - ☐ Yes ☐ No
- ☐ Decreased force of stream *(If checked, is force of stream markedly decreased?)*
  - ☐ Yes ☐ No
- ☐ Stricture disease requiring dilatation 1 to 2 times per year
- ☐ Stricture disease requiring periodic dilatation every 2 to 3 months
- ☐ Recurrent urinary tract infections secondary to obstruction
- ☐ Uroflowmetry peak flow rate less than 10 cc/sec
- ☐ Post void residuals greater than 150 cc
- ☐ Urinary retention requiring intermittent or continuous catheterization

3I. DOES THE VETERAN HAVE VOIDING DYSFUNCTION REQUIRING THE USE OF AN APPLIANCE?

☐ YES ☐ NO

IF YES, DESCRIBE: _____

3J. DOES THE VETERAN HAVE A HISTORY OF RECURRENT SYMPTOMATIC URINARY TRACT INFECTIONS?

☐ YES ☐ NO

IF YES, CHECK ALL TREATMENTS THAT APPLY:

- ☐ No treatment
- ☐ Long-term drug therapy

  (If checked, list medications used for urinary tract infection and indicate dates for courses of treatment over the past 12 months)

  _____
- ☐ Hospitalization

  (If checked, indicate frequency of hospitalization)
  - ☐ 1 or 2 per year
  - ☐ More than 2 per year
- ☐ Drainage

  IF CHECKED, INDICATE DATES WHEN DRAINAGE PERFORMED OVER PAST 12 MONTHS: _____
- ☐ Other management/treatment not listed above *(Description of management/treatment including dates of treatment)*:

  _____

SECTION III - CONDITIONS, SIGNS, AND SYMPTOMS *(Continued)*

3K. DOES THE VETERAN *(if male)* HAVE ERECTILE DYSFUNCTION?

☐ YES ☐ NO

IF YES, IS THE ERECTILE DYSFUNCTION AS LIKELY AS NOT (AT LEAST 50% PROBABILITY) ATTRIBUTABLE TO A CNS DISEASE (INCLUDING TREATMENT OR RESIDUALS OF TREATMENT?

☐ YES ☐ NO

IF NO, PROVIDE THE ETIOLOGY OF THE ERECTILE DYSFUNCTION:

IF YES, IS THE VETERAN ABLE TO ACHIEVE AN ERECTION (WITHOUT MEDICATION) SUFFICIENT FOR PENETRATION AND EJACULATION?

☐ YES ☐ NO

IF NO, IS THE VETERAN ABLE TO ACHIEVE AN ERECTION (WITH MEDICATION) SUFFICIENT FOR PENETRATION AND EJACULATION?

☐ YES ☐ NO

SECTION IV - NEUROLOGIC EXAM

4A. SPEECH

☐ NORMAL ☐ ABNORMAL

If speech is abnormal, describe:

4B. GAIT

☐ NORMAL ☐ ABNORMAL, DESCRIBE:

If gait is abnormal and the veteran has more than one medical condition contributing to the abnormal gait, identify the conditions and describe each condition's contribution to the abnormal gait:

4C. STRENGTH - 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

☐ ALL NORMAL

Elbow 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
Elbow 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
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
Grip:	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
Pinch *(thumb to index finger)*:	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

SECTION IV - NEUROLOGIC EXAM *(Continued)*

4D. DEEP TENDON REFLEXES (DTRs) - Rate reflexes according to the following scale:

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

4E. DOES THE VETERAN HAVE MUSCLE ATROPHY ATTRIBUTABLE TO A CNS CONDITION?

☐ YES ☐ NO

IF MUSCLE ATROPHY IS PRESENT, INDICATE LOCATION(S): *(If more than 1 location, please use Section XIII: Remarks.)*

_____

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

4F. SUMMARY OF MUSCLE WEAKNESS IN THE UPPER AND/OR LOWER EXTREMITIES ATTRIBUTABLE TO A CNS CONDITION *(check all that apply)*:

Right upper extremity muscle weakness:
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ With atrophy ☐ Complete *(no remaining function)*

Left upper extremity muscle weakness:
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ With atrophy ☐ Complete *(no remaining function)*

Right lower extremity muscle weakness:
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ With atrophy ☐ Complete *(no remaining function)*

Left lower extremity muscle weakness:
☐ None ☐ Mild ☐ Moderate ☐ Severe ☐ With atrophy ☐ Complete *(no remaining function)*

4G. IF THE VETERAN HAS MORE THAN ONE MEDICAL CONDITION CONTRIBUTING TO THE MUSCLE WEAKNESS, IDENTIFY THE CONDITION(S) AND DESCRIBE EACH CONDITION'S CONTRIBUTION TO THE MUSCLE WEAKNESS:

SECTION V - TUMORS AND NEOPLASMS

5A. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO

IF YES, COMPLETE THE FOLLOWING:

5B. IS THE NEOPLASM?

☐ BENIGN ☐ MALIGNANT

5C. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

☐ YES ☐ NO; WATCHFUL WAITING

IF YES, INDICATE TYPE OF TREATMENT THE VETERAN IS CURRENTLY UNDERGOING OR HAS COMPLETED (CHECK ALL THAT APPLY):

☐ Treatment completed; currently in watchful waiting status

☐ Surgery - If checked, describe: _____ Date(s) of surgery: _____

☐ Radiation therapy - Date of most recent treatment _____ Date of completion of treatment or anticipated date of completion: _____

☐ Antineoplastic chemotherapy - Date of most recent treatment: _____ Date of completion of treatment or anticipated date of completion: _____

☐ Other therapeutic procedure - If checked, describe procedure: _____ Date of most recent procedure: _____

☐ Other therapeutic treatment - If checked, describe treatment: _____ Date of completion of treatment or anticipated date of completion: _____

5D. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (including metastases) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT ABOVE?

☐ YES ☐ NO

IF YES, LIST RESIDUAL CONDITIONS AND COMPLICATIONS *(brief summary)*:

5E. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN SECTION I, DIAGNOSIS, DESCRIBE USING THE ABOVE FORMAT:

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

6A. DOES THE VETERAN HAVE ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO

IF YES, ARE ANY OF THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM (6 square inches); OR ARE LOCATED ON THE HEAD, FACE OR NECK?

☐ YES ☐ NO

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

IF NO, PROVIDE LOCATION AND MEASURMENTS OF SCAR IN CENTIMETERS.

LOCATION: _____

MEASUREMENTS: Length _____ cm X width _____ cm.

NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in the Remarks section below. It is not necessary to also complete a Scars DBQ.

6B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO

IF YES, DESCRIBE *(brief summary)*:

SECTION VII - MENTAL HEALTH MANIFESTATIONS DUE TO CNS CONDITION OR ITS TREATMENT

7A. DOES THE VETERAN HAVE DEPRESSION, COGNITIVE IMPAIRMENT OR DEMENTIA, OR ANY OTHER MENTAL HEALTH CONDITIONS ATTRIBUTABLE TO A CNS DISEASE AND/OR ITS TREATMENT?

☐ YES ☐ NO

7B. DOES THE VETERAN'S MENTAL HEALTH CONDITION(S), AS IDENTIFIED IN ITEM 7A, RESULT IN GROSS IMPAIRMENT IN THOUGHT PROCESSES OR COMMUNICATION?

☐ YES ☐ NO

IF NO, ALSO COMPLETE VA FORM 21-0960P-2, MENTAL DISORDERS *(Other than PTSD and Eating Disorders)* DISABILITY BENEFITS QUESTIONNAIRE *(SCHEDULE WITH APPROPRIATE PROVIDER)*.

IF YES, BRIEFLY DESCRIBE THE VETERAN'S MENTAL HEALTH CONDITION:

SECTION VIII - DIFFERENTIATION OF SYMPTOMS OR NEUROLOGIC EFFECTS

8. ARE YOU ABLE TO DIFFERENTIATE WHAT PORTION OF THE SYMPTOMATOLOGY OR NEUROLOGIC EFFECTS DESCRIBED IN ITEM 7B IS CAUSED BY EACH DIAGNOSIS?

☐ YES ☐ NO

IF YES, LIST WHICH SYMPTOMS OR NEUROLOGIC EFFECTS ARE ATTRIBUTABLE TO EACH DIAGNOSIS, WHERE POSSIBLE:

SECTION IX - ASSISTIVE DEVICES

9. 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

9B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION X - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

10. DUE TO A CNS 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., while functions for 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 ☐ Right lower ☐ Left lower

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

SECTION XI - DIAGNOSTIC TESTING

NOTE - If the results of MRI, other imaging studies or other diagnostic tests are in the medical record and reflect the veterans's current condition, repeat testing is not required. If pulmonary function testing (PFT) is indicated due to respiratory disability, and results are in the medical record and reflect the veteran's current respiratory function, repeat testing is not required. DLCO and bronchodilator testing is not indicated for a restrictive respiratory disability such as that caused by muscle weakness due to CNS conditions.

11A. HAVE IMAGING STUDIES BEEN PERFORMED?

☐ YES ☐ NO

IF YES, PROVIDE MOST RECENT RESULTS, IF AVAILABLE: _____

11B. HAVE PFTs BEEN PERFORMED?

☐ YES ☐ NO

IF YES, PROVIDE MOST RECENT RESULTS, IF AVAILABLE:

FEV1: _____ % predicted Date of test: _____

FEV1/FVC: _____ Date of test: _____

FEV: _____ % predicted Date of test: _____

11C. IF PFTs HAVE BEEN PERFORMED, IS THE FLOW-VOLUME LOOP COMPATIBLE WITH UPPER AIRWAY OBSTRUCTION?

☐ YES ☐ NO

11D. 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 XII - FUNCTIONAL IMPACT

12. DO THE VETERAN'S CENTRAL NERVOUS SYSTEM DISORDERS IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO

IF YES, DESCRIBE IMPACT OF EACH OF THE VETERAN'S CENTRAL NERVOUS SYSTEM DISORDER CONDITION(S) PROVIDING ONE OR MORE EXAMPLES:

SECTION XIII - REMARKS

13. 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.

14A. PHYSICIAN'S SIGNATURE	14B. PHYSICIAN'S PRINTED NAME	14C. DATE SIGNED

14D. PHYSICIAN'S PHONE NUMBER AND FAX NUMBER	14E. PHYSICIAN'S MEDICAL LICENSE NUMBER	14F. 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.benefits.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 voluntary. 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 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.