OMB Control No. 2900-0781
Respondent Burden: 15 Minutes
Expiration Date: XX/XX/XXXX

Department of Veterans Affairs

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 THIS 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 CHRONIC FATIGUE SYNDROME?

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

NOTE: These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. 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 appropriate date determined through record review or reported history.

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

☐ CHRONIC FATIGUE SYNDROME ICD Code: _____ Date of diagnosis: _____

☐ OTHER *(specify)*

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 CHRONIC FATIGUE SYNDROME, LIST USING ABOVE FORMAT:

NOTE - For VA purposes, the diagnosis of chronic fatigue syndrome requires:
(A) New onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the usual level for at least 6 months; and
(B) The exclusion, by history, physical examination, and laboratory tests, of all other clinical conditions that may produce similar symptoms; and
(C) Six or more of the following:

1. Acute onset of the condition
2. Low grade fever
3. Non-exudative pharyngitis
4. Palpable or tender cervical or axillary lymph nodes
5. Generalized muscle aches or weakness
6. Fatigue lasting 24 hours or longer after exercise
7. Headaches (of a type, severity or pattern that is different from headaches in the pre-morbid state)
8. Migratory joint pains
9. Neuropsychological symptoms
10. Sleep disturbance

SECTION II - MEDICAL RECORD REVIEW

2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARATION OF THIS REPORT:

☐ C-FILE (VA ONLY)

☐ OTHER, DESCRIBE:

SECTION III - MEDICAL HISTORY

3A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S CHRONIC FATIGUE SYNDROME *(brief summary):*

3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF CHRONIC FATIGUE SYNDROME?

☐ YES ☐ NO

(If "Yes," are the veteran's symptoms controlled by continuous medication?)

☐ YES ☐ NO

(If "Yes," list only those medications required for the veteran's chronic fatigue syndrome):

3C. HAVE OTHER CLINICAL CONDITIONS THAT MAY PRODUCE SIMILAR SYMPTOMS BEEN EXCLUDED BY HISTORY, PHYSICAL EXAMINATION AND/OR LABORATORY TESTS TO THE EXTENT POSSIBLE?

☐ YES ☐ NO *(If "No," describe):*

3D. DID THE VETERAN HAVE AN ACUTE ONSET OF CHRONIC FATIGUE SYNDROME?

☐ YES ☐ NO

3E. HAS THE DEBILITATING FATIGUE REDUCED DAILY ACTIVITY LEVEL TO LESS THAN 50% OF PRE-ILLNESS LEVEL?

☐ YES ☐ NO

(If "Yes," specify length of time daily activity level has been reduced to less than 50% of pre-illness level):

☐ Less than 6 months ☐ 6 months or longer

SECTION IV - FINDINGS, SIGNS AND SYMPTOMS

4A. DOES THE VETERAN NOW HAVE OR HAS THE VETERAN HAD ANY FINDINGS, SIGNS AND SYMPTOMS ATTRIBUTABLE TO CHRONIC FATIGUE SYNDROME?

☐ YES ☐ NO

(If "Yes," check all that apply):

- ☐ Debilitating fatigue
- ☐ Low grade fever
- ☐ Nonexudative pharyngitis
- ☐ Palpable or tender cervical or axillary lymph nodes
- ☐ Generalized muscle aches or weakness
- ☐ Fatigue lasting 24 hours or longer after exercise
- ☐ Headaches *(of a type, severity or pattern that is different from headaches in the pre-morbid state)*
- ☐ Migratory joint pain
- ☐ Neuropsychologic symptoms
- ☐ Sleep disturbance
- ☐ Other

(Note: Describe all checked conditions in Item 4B)

4B. PROVIDE A DESCRIPTION OF THE CONDITION(S):

4C. DOES THE VETERAN NOW HAVE OR HAS THE VETERAN HAD ANY COGNITIVE IMPAIRMENT ATTRIBUTABLE TO CHRONIC FATIGUE SYNDROME?

☐ YES ☐ NO

(If "Yes," check all that apply):

- ☐ Poor attention
- ☐ Inability to concentrate
- ☐ Forgetfulness
- ☐ Confusion
- ☐ Other cognitive impairments

(Note: Describe all checked conditions in Item 4D)

4D. PROVIDE A DESCRIPTION OF THE CONDITION(S):

4E. SPECIFY FREQUENCY OF SYMPTOMS:

- ☐ Symptoms wax and wane
- ☐ Symptoms are nearly constant
- ☐ Other

(Note: Describe frequency in Item 4F)

4F. PROVIDE A DESCRIPTION OF THE FREQUENCY:

4G. DO THE VETERAN'S SYMPTOMS DUE TO CHRONIC FATIGUE SYNDROME RESTRICT ROUTINE DAILY ACTIVITIES AS COMPARED TO THE PRE-ILLNESS LEVEL?

☐ YES ☐ NO

(If "Yes," specify % of restriction (check all that apply)):

- ☐ Symptoms restrict routine daily activities by less than 25 % of the pre-illness level *(more than 75% of the pre-illness level of activities are not restricted)*
- ☐ Symptoms restrict routine daily activities to 50% to 75% of the pre-illness level
- ☐ Symptoms restrict routine daily activities to less than 50% of the pre-illness level
- ☐ Symptoms are so severe as to restrict routine daily activities almost completely
- ☐ Symptoms are so severe as to occasionally preclude self-care *(If checked, describe frequency with which this occurs):* _____
- ☐ Other *(describe):* _____

NOTE: For VA purposes, chronic fatigue syndrome is considered incapacitating only while it requires bed rest and treatment by a physician.

4H. DO THE VETERAN'S SYMPTOMS DUE TO CHRONIC FATIGUE SYNDROME RESULT IN PERIODS OF INCAPACITATION?

☐ YES ☐ NO

(If "Yes," indicate total duration of periods of incapacitation over the past 12 months):

- ☐ Less than 1 week
- ☐ At least 1 but less than 2 weeks
- ☐ At least 2 but less than 4 weeks
- ☐ At least 4 but less than 6 weeks
- ☐ At least 6 weeks total duration per year
- ☐ Other *(describe):* _____

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

5A. 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 AND/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 (DBQ)*.

IF "NO," PROVIDE LOCATION AND MEASUREMENTS 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. It is not necessary to also complete a Scars/Disfigurement DBQ.

5B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS OF CHRONIC FATIGUE SYNDROME?

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

SECTION VI - DIAGNOSTIC TESTING

NOTE: If testing has been performed and reflects the veteran's current condition, repeat testing is not required.

6. ARE THERE ANY SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☐ NO *(If "Yes," provide type of test or procedure, date and results - brief summary):*

SECTION VII - FUNCTIONAL IMPACT

7. DOES THE VETERAN'S CHRONIC FATIGUE SYNDROME IMPACT ON HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO *(If "Yes," describe the impact of the veteran's chronic fatigue syndrome, providing one or more examples):*

SECTION VIII - REMARKS

8. REMARKS *(If any):*

SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9A. PHYSICIAN'S SIGNATURE	9B. PHYSICIAN'S PRINTED NAME	9C. DATE SIGNED

9D. PHYSICIAN'S PHONE AND FAX NUMBERS	9E. PHYSICIAN'S MEDICAL LICENSE NUMBER	9F. 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, 58/VA21/22/28, 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 15 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.