



**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 ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

-                      -

**NOTE TO PHYSICIAN** - The veteran or service member 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 claim. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

**MEDICAL RECORD REVIEW**

WAS THE VETERAN'S VA CLAIMS FILE REVIEWED?

YES     NO

IF YES, LIST ANY RECORDS THAT WERE REVIEWED BUT WERE NOT INCLUDED IN THE VETERAN'S VA CLAIMS FILE:

IF NO, CHECK ALL RECORDS REVIEWED:

- |   |   |
|---|---|
| <input type="checkbox"/> Military service treatment records     | <input type="checkbox"/> Department of Defense Form 214 Separation Documents  |
| <input type="checkbox"/> Military service personnel records     | <input type="checkbox"/> Veterans Health Administration medical records ( <i>VA treatment records</i> )   |
| <input type="checkbox"/> Military enlistment examination        | <input type="checkbox"/> Civilian medical records   |
| <input type="checkbox"/> Military separation examination        | <input type="checkbox"/> Interviews with collateral witnesses ( <i>family and others who have known the veteran before and after military service</i> ) |
| <input type="checkbox"/> Military post-deployment questionnaire | <input type="checkbox"/> Other: _____   |
| <input type="checkbox"/> No records were reviewed               |   |

**SECTION I - DIAGNOSIS**

**NOTE:** These are condition(s) for which an evaluation has been requested on an exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. LIST THE CLAIMED CONDITION(S) THAT PERTAIN TO THIS DBQ:

**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 comments section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date determined through record review or reported history.

1B. SELECT DIAGNOSES ASSOCIATED WITH THE CLAIMED CONDITION(S) (*Check all that apply*):

- The Veteran does not have a current diagnosis associated with any claimed condition listed above. (*Explain your findings and reasons in comments section.*)
- |   |                 |                          |
|---|-----------------|--------------------------|
| <input type="checkbox"/> Mechanical back pain syndrome  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Lumbosacral sprain/strain  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Facet joint arthropathy ( <i>degenerative joint disease of lumbosacral spine</i> ) | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Degenerative disc disease  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Degenerative scoliosis   | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Foraminal/lateral recess/central stenosis  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Degenerative spondylolisthesis   | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Spondylolysis/isthmic spondylolisthesis  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Intervertebral disc syndrome   | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Radiculopathy  | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Ankylosis of thoracolumbar spine   | ICD Code: _____ | Date of diagnosis: _____ |
| <input type="checkbox"/> Ankylosing spondylitis of the thoracolumbar spine ( <i>back</i> )                  | ICD Code: _____ | Date of diagnosis: _____ |

**NOTE:** If there are systemic or other constitutional manifestations of ankylosing spondylitis, ALSO complete the Non-degenerative Arthritis DBQ and the appropriate DBQ for each affected system.

- Vertebral fracture (*vertebrae of the back*)                      ICD Code: \_\_\_\_\_                      Date of diagnosis: \_\_\_\_\_

**SECTION I - DIAGNOSIS (Continued)**

1B. SELECT DIAGNOSES ASSOCIATED WITH THE CLAIMED CONDITION(S) (Check all that apply) (Continued):

Other (specify)  
 Other diagnosis #1: \_\_\_\_\_  
 ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_  
 Other diagnosis #2: \_\_\_\_\_  
 ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_  
 Other diagnosis #3: \_\_\_\_\_  
 ICD Code: \_\_\_\_\_ Date of diagnosis: \_\_\_\_\_

1C. COMMENTS (if any):

1D. WAS AN OPINION REQUESTED ABOUT THIS CONDITION (internal VA only)?

YES  NO  N/A

**SECTION II - MEDICAL HISTORY**

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

2B. 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:

2C. DOES THE VETERAN REPORT HAVING ANY FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT OF THE THORACOLUMBAR SPINE (back) (regardless of repetitive use)?

YES  NO

IF YES, DOCUMENT THE VETERAN'S DESCRIPTION OF FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT IN HIS OR HER OWN WORDS:

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

Measure ROM with a goniometer. During the examination be cognizant of painful motion, which could be evidenced by visible behavior such as facial expression, wincing, etc..., on pressure or manipulation. Document painful movement in Section 5.

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 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 question 4A.

3A. INITIAL ROM MEASUREMENTS

	Joint Movement	ROM Measurement	If ROM testing is not indicated for the veteran's condition or not able to be performed, please explain why, and then proceed to Section 5:
BACK	Forward Flexion (normal endpoint = 90 degrees)	<input type="checkbox"/> Not indicated <input type="checkbox"/> Not able to perform	
	Extension (normal endpoint = 30 degrees)	<input type="checkbox"/> Not indicated <input type="checkbox"/> Not able to perform	
	Right Lateral Flexion (normal endpoint = 30 degrees)	<input type="checkbox"/> Not indicated <input type="checkbox"/> Not able to perform	
	Left Lateral Flexion (normal endpoint = 30 degrees)	<input type="checkbox"/> Not indicated <input type="checkbox"/> Not able to perform	
	Right Lateral Rotation (normal endpoint = 30 degrees)	<input type="checkbox"/> Not indicated <input type="checkbox"/> Not able to perform	
	Left Lateral Rotation (normal endpoint = 30 degrees)	<input type="checkbox"/> Not indicated <input type="checkbox"/> Not able to perform	

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

3B. DO ANY ABNORMAL ROMs NOTED ABOVE CONTRIBUTE TO FUNCTIONAL LOSS?

- YES (you will be asked to further describe these limitations in Section 7 below)  
 NO, EXPLAIN WHY THE ABNORMAL ROMs DO NOT CONTRIBUTE:

3C. IF ROM 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 IV - ROM MEASUREMENTS AFTER REPETITIVE USE TESTING**

4A. POST-TEST ROM MEASUREMENTS

Is the veteran able to perform repetitive-use testing?	Is there additional limitation in ROM after repetitive-use testing?	Joint Movement	Post-test ROM Measurement
<input type="checkbox"/> Yes If yes, perform repetitive-use testing <input type="checkbox"/> No If no, provide reason below, then proceed to Section 5	<input type="checkbox"/> Yes <input type="checkbox"/> No, there is no change in ROM after repetitive testing  If yes, report ROM after a minimum of 3 repetitions.  If no, documentation of ROM after repetitive-use testing is not required.	Forward Flexion	_____
		Extension	_____
		Left Lateral Flexion	_____
		Right Lateral Flexion	_____
		Left Lateral Rotation	_____
		Right Lateral Rotation	_____

4B. DO ANY POST-TEST ADDITIONAL LIMITATIONS OF ROMs NOTED ABOVE CONTRIBUTE TO FUNCTIONAL LOSS?

- YES (you will be asked to further describe these limitations in Section 7 below)  
 NO, EXPLAIN WHY THE POST-TEST ADDITIONAL LIMITATIONS OF ROMs DO NOT CONTRIBUTE:

**SECTION V - PAIN**

5A. ROM MOVEMENTS PAINFUL ON ACTIVE, PASSIVE AND/OR REPETITIVE USE TESTING

Are any ROM movements painful on active, passive and/or repetitive use testing? <i>(If yes, identify whether active, passive, and/or repetitive use in question 5D)</i>	If yes (there are painful movements), does the pain contribute to functional loss or additional limitation of ROM?	If no (the pain does not contribute to functional loss or additional limitation of ROM), explain why the pain does not contribute:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes (you will be asked to further describe these limitations in Section 7 below) <input type="checkbox"/> No	

5B. PAIN WHEN USED IN WEIGHT-BEARING OR IN NON WEIGHT-BEARING

Is there pain when the joint is used in weight-bearing or non weight-bearing? <i>(If yes, identify whether weight-bearing or non weight-bearing in question 5D)</i>	If yes (there is pain when used in weight-bearing or non weight-bearing), does the pain contribute to functional loss or additional limitation of ROM?	If no (the pain does not contribute to functional loss or additional limitation of ROM), explain why the pain does not contribute:
<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes (you will be asked to further describe these limitations in Section 7 below) <input type="checkbox"/> No	

5C. LOCALIZED TENDERNESS OR PAIN ON PALPATION

Does the Veteran have localized tenderness or pain to palpation of joints or soft tissue?	If yes, describe including location, severity and relationship to condition(s) listed in the Diagnosis section:
<input type="checkbox"/> Yes <input type="checkbox"/> No	

5D. COMMENTS, IF ANY:



**SECTION VII - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION OF ROM (Continued)**

**NOTE:** If any of the above factors is/are associated with limitation of motion, the examiner must give an opinion on whether pain, weakness, fatigability, or incoordination could significantly limit functional ability during flare-ups or when the joint is *used repeatedly over a period of time* and that opinion, if feasible, should be expressed in terms of the degree of additional ROM loss due to pain on use or during flare-ups. The following section will assist you in providing this required opinion.

7B. ARE ANY OF THE ABOVE FACTORS ASSOCIATED WITH LIMITATION OF MOTION?

- YES (If yes, complete question 7C and 7D)  
 NO (If no, proceed to question 7D)

7C. CONTRIBUTING FACTORS OF DISABILITY ASSOCIATED WITH LIMITATION OF MOTION

Can pain, weakness, fatigability, or incoordination significantly limit functional ability during flare-ups or when the joint is <i>used repeatedly over a period of time</i> ?  <input type="checkbox"/> Yes <input type="checkbox"/> No	If yes, please estimate ROM due to pain and/or functional loss during flare-ups or when the joint is used repeatedly over a period of time:	If there is a functional loss due to pain, during flare-ups and/or when the joint is used repeatedly over a period of time but the limitation of ROM cannot be estimated, please describe the functional loss:
	Forward Flexion    _____ <input type="checkbox"/> Est. ROM is not feasible	
	Extension    _____ <input type="checkbox"/> Est. ROM is not feasible	
	Right Lateral Flexion    _____ <input type="checkbox"/> Est. ROM is not feasible	
	Left Lateral Flexion    _____ <input type="checkbox"/> Est. ROM is not feasible	
	Right Lateral Rotation    _____ <input type="checkbox"/> Est. ROM is not feasible	
	Left Lateral Rotation    _____ <input type="checkbox"/> Est. ROM is not feasible	

7D. CONTRIBUTING FACTORS OF DISABILITY NOT ASSOCIATED WITH LIMITATION OF MOTION

IS THERE ANY FUNCTIONAL LOSS (not associated with limitation of motion) DURING FLARE-UPS OR WHEN THE JOINT IS USED REPEATEDLY OVER A PERIOD OF TIME OR OTHERWISE?

- YES     NO

IF YES, DESCRIBE:

**SECTION VIII - MUSCLE STRENGTH TESTING**

8A. MUSCLE STRENGTH - 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

Side	Flexion/Extension	Rate Strength	Is there a reduction in muscle strength?	If yes, is the reduction entirely due to the claimed condition in the Diagnosis section?	If no (the reduction is not entirely due to the claimed condition), provide rationale:
RIGHT	Hip Flexion	/5	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Knee Flexion	/5			
	Knee Extension	/5			
	Ankle Plantar Flexion	/5			
	Ankle Dorsiflexion	/5			
	Foot Abduction	/5			
	Foot Adduction	/5			
	Great Toe Extension	/5			

**SECTION VIII - MUSCLE STRENGTH TESTING (Continued)**

8A. MUSCLE STRENGTH - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE (Continued):

- 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

Side	Flexion/Extension	Rate Strength	Is there a reduction in muscle strength?	If yes, is the reduction entirely due to the claimed condition in the Diagnosis section?	If no (the reduction is not entirely due to the claimed condition), provide rationale:
LEFT	Hip Flexion	/5	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Knee Flexion	/5			
	Knee Extension	/5			
	Ankle Plantar Flexion	/5			
	Ankle Dorsiflexion	/5			
	Foot Abduction	/5			
	Foot Adduction	/5			
	Great Toe Extension	/5			

8B. DOES THE VETERAN HAVE MUSCLE ATROPHY?

- YES  NO

IF YES, IS THE MUSCLE ATROPHY DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION?

- YES  NO IF NO, PROVIDE RATIONALE:

FOR ANY MUSCLE ATROPHY DUE TO A DIAGNOSES LISTED IN SECTION 1, INDICATE SIDE AND SPECIFIC LOCATION OF ATROPHY, PROVIDING MEASUREMENTS IN CENTIMETERS OF NORMAL SIDE AND CORRESPONDING ATROPHIED SIDE, MEASURED AT MAXIMUM MUSCLE BULK.

LOCATION OF MUSCLE ATROPHY:

- RIGHT LOWER EXTREMITY (specify location of measurement such as "10cm above or below elbow"):

CIRCUMFERENCE OF MORE NORMAL SIDE: \_\_\_\_\_ CM CIRCUMFERENCE OF ATROPHIED SIDE: \_\_\_\_\_ CM

- LEFT LOWER EXTREMITY (specify location of measurement such as "10cm above or below elbow"):

CIRCUMFERENCE OF MORE NORMAL SIDE: \_\_\_\_\_ CM CIRCUMFERENCE OF ATROPHIED SIDE: \_\_\_\_\_ CM

8C. COMMENTS, IF ANY:

**SECTION IX - ANKYLOSIS**

COMPLETE THIS SECTION IF VETERAN HAS ANKYLOSIS OF THE THORACOLUMBAR SPINE (back).

**NOTE:** For VA compensation purposes, unfavorable ankylosis is a condition in which the entire cervical spine, the entire thoracolumbar spine, or the entire spine is fixed in flexion or extension, and the ankylosis results in one or more of the following: difficulty walking because of a limited line of vision; restricted opening of the mouth and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms due to pressure of the costal margin on the abdomen; dyspnea or dysphagia; atlantoaxial or cervical subluxation or dislocation; or neurologic symptoms due to nerve root stretching. Fixation of a spinal segment in neutral position (0 degrees) always represents favorable ankylosis.

9A. INDICATE SEVERITY OF ANKYLOSIS:

- Favorable ankylosis of the entire thoracolumbar spine
- Unfavorable ankylosis of the entire thoracolumbar spine
- Unfavorable ankylosis of the entire spine (cervical and thoracolumbar)
- No ankylosis

9B. COMMENTS, IF ANY:

**SECTION X - REFLEX EXAM**

10A. DEEP TENDON REFLEXES - RATE DEEP TENDON REFLEXES (DTRs) ACCORDING TO THE FOLLOWING SCALE:

- |                               |        |       |   |        |   |
|-------------------------------|--------|-------|---|--------|---|
| 0 Absent                      |        |       |   |        |   |
| 1+ Hypoactive                 | RIGHT: | KNEE: | + | ANKLE: | + |
| 2+ Normal                     |        |       |   |        |   |
| 3+ Hyperactive without clonus | LEFT:  | KNEE: | + | ANKLE: | + |
| 4+ Hyperactive with clonus    |        |       |   |        |   |

**SECTION X - REFLEX EXAM (Continued)**

10B. COMMENTS, IF ANY:

**SECTION XI - SENSORY EXAM**

11A. RESULTS FOR SENSATION TO LIGHT TOUCH (*dermatome*) TESTING:

Side	Upper Anterior Thigh (L2)	Thigh/Knee (L3/4)	Lower Leg/Ankle (L4/L5/S1)	Foot/Toes (L5)
RIGHT	<input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Absent	<input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Absent	<input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Absent	<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	<input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Absent	<input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Absent	<input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Absent

11B. WERE OTHER SENSORY TESTS INDICATED AND PERFORMED?

YES  NO

IF YES, INDICATE RESULTS:

Side	Position Sense ( <i>grasp great toe on sides and ask patient to identify up and down movement</i> ) <input type="checkbox"/> Not tested	Vibration Sensation ( <i>place low-pitched tuning fork over IP joint of great toe</i> ) <input type="checkbox"/> Not tested	Cold Sensation ( <i>test distal extremities for cold sensation with side of tuning fork or other cold object</i> ) <input type="checkbox"/> Not tested
RIGHT	<input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Absent	<input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Absent	<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	<input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Absent	<input type="checkbox"/> Normal <input type="checkbox"/> Decreased <input type="checkbox"/> Absent

11C. OTHER SENSORY FINDINGS, IF ANY:

**SECTION XII - STRAIGHT LEG RAISING TEST**

**NOTE:** 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 limited to the back or hamstring muscles. Pain is often increased on dorsiflexion of the foot, and relieved by knee flexion. A positive test suggests radiculopathy, often due to disc herniation.

12. PROVIDE STRAIGHT LEG RAISING TEST RESULTS:

RIGHT:  NEGATIVE  POSITIVE  UNABLE TO PERFORM

LEFT:  NEGATIVE  POSITIVE  UNABLE TO PERFORM

**SECTION XIII - RADICULOPATHY**

**NOTE:** Radiculopathy is considered to be any condition due to disease of the nerve roots and nerves located in the back.

13A. DOES THE VETERAN HAVE RADICULAR PAIN OR ANY OTHER SUBJECTIVE SYMPTOMS DUE TO RADICULOPATHY?

YES  NO

IF YES, COMPLETE QUESTIONS 13B-13K, INCLUDING SYMPTOMS, SEVERITY OF RADICULOPATHY AND NERVE ROOTS INVOLVED (*check all that apply*)

IF THE VETERAN REPORTED RADICULAR-TYPE SYMPTOMS IN THE MEDICAL HISTORY SECTION ABOVE THAT YOU FIND ARE NOT DUE TO RADICULOPATHY, PLEASE PROVIDE RATIONALE:

13B. CONSTANT PAIN, AT TIMES EXCRUCIATING (*subjective symptom*)

Present  Absent (*does not occur*)  Pain is present, but not due to radiculopathy (*if checked, provide rationale in question 13K below*)

If present, indicate location and severity:

Right lower extremity:  None  Mild  Moderate  Severe

Left lower extremity:  None  Mild  Moderate  Severe

13C. INTERMITTENT PAIN (*subjective symptom*)

Present  Absent (*does not occur*)  Pain is present, but not due to radiculopathy (*if checked, provide rationale in question 13K below*)

If present, indicate location and severity:

Right lower extremity:  None  Mild  Moderate  Severe

Left lower extremity:  None  Mild  Moderate  Severe

13D. DULL PAIN (*subjective symptom*)

Present  Absent (*does not occur*)  Pain is present, but not due to radiculopathy (*if checked, provide rationale in question 13K below*)

If present, indicate location and severity:

Right lower extremity:  None  Mild  Moderate  Severe

Left lower extremity:  None  Mild  Moderate  Severe

**SECTION XIII - RADICULOPATHY (Continued)**

13E. PARESTHESIAS AND/OR DYSESTHESIAS (*subjective symptom*)

Present  Absent (*does not occur*)  Paresthesias and/or dysesthesias are present, but not due to radiculopathy (*if checked, provide rationale in question 13K below*)

If present, indicate location and severity:

Right lower extremity:  None  Mild  Moderate  Severe  
 Left lower extremity:  None  Mild  Moderate  Severe

13F. NUMBNESS (*subjective symptom*)

Present  Absent (*does not occur*)  Numbness is present, but not due to radiculopathy (*if checked, provide rationale in question 13K below*)

If present, indicate location and severity:

Right lower extremity:  None  Mild  Moderate  Severe  
 Left lower extremity:  None  Mild  Moderate  Severe

13G. DOES THE VETERAN HAVE ANY OBJECTIVE FINDINGS DUE TO RADICULOPATHY NOT ADDRESSED IN THE PHYSICAL EXAM SECTION?

YES  NO

IF YES, DESCRIBE:

13H. INDICATE SEVERITY OF RADICULOPATHY (*evaluate severity by incorporating the effects of subjective symptoms and objective findings, if any*) AND SIDE AFFECTED:

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

13I. SPECIFY NERVE ROOTS INVOLVED (*check all that apply*):

INVOLVEMENT OF L2/L3/L4 NERVE ROOTS (*femoral nerve*)  
 If checked, indicate side affected:  Right  Left  Both

INVOLVEMENT OF L4/L5/S1/S2/S3 NERVE ROOTS (*sciatic nerve*)  
 If checked, indicate side affected:  Right  Left  Both

OTHER NERVES (*specify nerve root involved*):  
 If checked, indicate side affected:  Right  Left  Both

13J. DOMINANT HAND

RIGHT  LEFT  AMBIDEXTROUS

13K. COMMENTS, IF ANY:

**SECTION XIV - OTHER NEUROLOGIC ABNORMALITIES**

14. DOES THE VETERAN HAVE ANY OTHER OBJECTIVE NEUROLOGIC ABNORMALITIES OR FINDINGS (*including, but not limited to bowel or bladder problems*) ASSOCIATED WITH A THORACOLUMBAR SPINE (*back*) CONDITION?

YES  NO

IF YES, DESCRIBE CONDITION AND ITS RELATIONSHIP TO ANY CONDITION LISTED IN THE DIAGNOSIS SECTION:

**NOTE:** If there are neurological abnormalities other than those addressed in the Physical Exam or Radiculopathy sections above, ALSO complete appropriate Disability Benefits Questionnaire for each condition identified.

**SECTION XV - INTERVERTEBRAL DISC SYNDROME (IVDS) AND INCAPACITATING EPISODES**

**NOTE:** For VA purposes, IVDS is a group of signs and symptoms due to nerve root irritation that commonly includes back pain and sciatica (pain along the course of the sciatic nerve) in the case of lumbar disc disease, and neck and arm or hand pain in the case of cervical disc disease.

15A. DOES THE VETERAN HAVE IVDS OF THE THORACOLUMBAR SPINE?

YES  NO

15B. IF YES TO QUESTION 15A ABOVE, HAS THE VETERAN HAD ANY INCAPACITATING EPISODES (*a period of acute signs and symptoms due to IVDS that requires bed rest prescribed by a physician and treatment by a physician*) OVER THE PAST 12 MONTHS?

YES  NO

15C. IF YES TO QUESTION 15B ABOVE, PROVIDE THE TOTAL DURATION OF ALL 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 - INTERVERTEBRAL DISC SYNDROME (IVDS) AND INCAPACITATING EPISODES (Continued)**

15D. COMMENTS, IF ANY:

**SECTION XVI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS AND SCARS**

16A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS, OR ANY SCARS (surgical or otherwise) RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES  NO IF YES, COMPLETE QUESTIONS 16B-16D.

16B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

YES  NO IF YES, DESCRIBE (brief summary):

16C. 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 ABOVE?

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.

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 Comment section below. It is not necessary to also complete a Scars DBQ.

16D. COMMENTS, IF ANY:

**SECTION XVII - ASSISTIVE DEVICES**

17A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

YES  NO IF YES, IDENTIFY ASSISTIVE DEVICES 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        | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Crutches     | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Cane         | 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 |

17B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

**SECTION XVIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES**

18. DUE TO THE VETERAN'S 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., while functions for the lower extremity include balance and propulsion, etc.)

YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROTHESIS WOULD EQUALLY SERVE THE VETERAN.  
 NO

IF YES, INDICATE EXTREMITIES FOR WHICH THIS APPLIES:  RIGHT LOWER  LEFT LOWER

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

**NOTE:** The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prosthesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.



