OMB Approved No. 2900-0808
Respondent Burden: 45 minutes
Expiration Date: XXXXXXX

Department of Veterans Affairs

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:

- ☐ Military service treatment records
- ☐ Military service personnel records
- ☐ Military enlistment examination
- ☐ Military separation examination
- ☐ Military post-deployment questionnaire
- ☐ Department of Defense Form 214 Separation Documents
- ☐ Veterans Health Administration medical records *(VA treatment records)*
- ☐ Civilian medical records
- ☐ Interviews with collateral witnesses *(family and others who have known the veteran before and after military service)*
- ☐ Other: _____
- ☐ 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.)*

☐ Mechanical back pain syndrome	ICD Code: _____	Date of diagnosis: _____
☐ Lumbosacral sprain/strain	ICD Code: _____	Date of diagnosis: _____
☐ Facet joint arthropathy *(degenerative joint disease of lumbosacral spine)*	ICD Code: _____	Date of diagnosis: _____
☐ Degenerative disc disease	ICD Code: _____	Date of diagnosis: _____
☐ Degenerative scoliosis	ICD Code: _____	Date of diagnosis: _____
☐ Foraminal/lateral recess/ central stenosis	ICD Code: _____	Date of diagnosis: _____
☐ Degenerative spondylolisthesis	ICD Code: _____	Date of diagnosis: _____
☐ Spondylolysis/isthmic spondylolisthesis	ICD Code: _____	Date of diagnosis: _____
☐ Intervertebral disc syndrome	ICD Code: _____	Date of diagnosis: _____
☐ Radiculopathy	ICD Code: _____	Date of diagnosis: _____
☐ Ankylosis of thoracolumbar spine	ICD Code: _____	Date of diagnosis: _____
☐ Ankylosing spondylitis of the thoracolumbar spine (*back)*	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: _____

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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

BACK

All Normal

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:
Forward Flexion (normal endpoint = 90 degrees)	_____ ☐ Not indicated ☐ Not able to perform	
Extension (normal endpoint = 30 degrees)	_____ ☐ Not indicated ☐ Not able to perform	
Right Lateral Flexion (normal endpoint = 30 degrees)	_____ ☐ Not indicated ☐ Not able to perform	
Left Lateral Flexion (normal endpoint = 30 degrees)	_____ ☐ Not indicated ☐ Not able to perform	
Right Lateral Rotation (normal endpoint = 30 degrees)	_____ ☐ Not indicated ☐ Not able to perform	
Left Lateral Rotation (normal endpoint = 30 degrees)	_____ ☐ Not indicated ☐ Not able to perform	

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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
☐ Yes If yes, perform repetitive-use testing ☐ No If no, provide reason below, then proceed to Section 5	☐ Yes ☐ 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? *(If yes, identify whether active, passive, and/or repetitive use in question 5D)*	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:
☐ Yes ☐ No	☐ Yes *(you will be asked to further describe these limitations in Section 7 below)* ☐ 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? *(If yes, identify whether weight-bearing or non weight-bearing in question 5D)*	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:
☐ Yes ☐ No	☐ Yes *(you will be asked to further describe these limitations in Section 7 below)* ☐ 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:
☐ Yes ☐ No	

5D. COMMENTS, IF ANY:

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SECTION VI - GUARDING AND MUSCLE SPASM

6A. DOES THE VETERAN HAVE GUARDING OR MUSCLE SPASM OF THE THORACOLUMBAR SPINE *(back)*?

☐ YES ☐ NO

6B. GAIT:

☐ NORMAL

☐ ABNORMAL

Due to:

- ☐ Muscle spasm
- ☐ Guarding
- ☐ Other, describe and provide etiology:

☐ UNABLE TO EVALUATE, PROVIDE REASON:

6C. SPINAL CONTOUR:

☐ NORMAL

☐ ABNORMAL

Due to:

- ☐ Muscle spasm
- ☐ Guarding
- ☐ Other, describe and provide etiology:

☐ UNABLE TO EVALUATE, PROVIDE REASON:

SECTION VII - FUNCTIONAL LOSS AND ADDITIONAL LIMITATION OF ROM

NOTE: The VA defines functional loss as the inability, due to damage or infection in parts of the system, to perform normal working movements of the body with normal excursion, strength, speed, coordination and/or endurance. As regards the joints, factors of disability reside in reductions of their normal excursion of movements in different planes.
Using information from the history and physical exam, select the factors below that contribute to functional loss or impairment (regardless of repetitive use) or to additional limitation of ROM after repetitive use for the joint or extremity being evaluated on this DBQ:

7A. CONTRIBUTING FACTORS OF DISABILITY *(check all that apply and indicate side affected)*:

☐ Less movement than normal *(due to ankylosis, limitation or blocking, adhesions, tendon-tie-ups, contracted scars, etc.)*

☐ More movement than normal *(from flail joints, resections, nonunion of fractures, relaxation of ligaments, etc.)*

☐ Weakened movement *(due to muscle injury, disease or injury of peripheral nerves, divided or lengthened tendons, etc.)*

☐ 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

☐ Interference with standing

☐ Other, describe:

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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 ***used repeatedly over a period of time?***	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:
☐ Yes ☐ No	Forward Flexion	_____ ☐ Est. ROM is not feasible	
	Extension	_____ ☐ Est. ROM is not feasible	
	Right Lateral Flexion	_____ ☐ Est. ROM is not feasible	
	Left Lateral Flexion	_____ ☐ Est. ROM is not feasible	
	Right Lateral Rotation	_____ ☐ Est. ROM is not feasible	
	Left Lateral Rotation	_____ ☐ 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 All Normal	Hip Flexion	/5	☐ Yes ☐ No	☐ Yes ☐ No	
	Knee Flexion	/5			
	Knee Extension	/5			
	Ankle Plantar Flexion	/5			
	Ankle Dorsiflexion	/5			
	Foot Abduction	/5			
	Foot Adduction	/5			
	Great Toe Extension	/5			

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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 All Normal	Hip Flexion	/5	☐ Yes ☐ No	☐ Yes ☐ 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
2+ Normal
3+ Hyperactive without clonus
4+ Hyperactive with clonus

RIGHT: All Normal KNEE: + ANKLE: +

LEFT: All Normal KNEE: + ANKLE: +

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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 All Normal	☐ Normal ☐ Decreased ☐ Absent	☐ Normal ☐ Decreased ☐ Absent	☐ Normal ☐ Decreased ☐ Absent	☐ Normal ☐ Decreased ☐ Absent
LEFT All Normal	☐ Normal ☐ Decreased ☐ Absent	☐ Normal ☐ Decreased ☐ Absent	☐ Normal ☐ Decreased ☐ Absent	☐ Normal ☐ Decreased ☐ Absent

11B. WERE OTHER SENSORY TESTS INDICATED AND PERFORMED?

☐ YES ☐ NO

IF YES, INDICATE RESULTS:

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

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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

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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):*

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Brace	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutches	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other: _____	Frequency of use:	☐ Occasional	☐ Regular	☐ 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 prothesis. 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.

PATIENT/VETERAN'S SOCIAL SECURITY NO. ☐☐☐ – ☐☐ – ☐☐☐☐

SECTION XIX - DIAGNOSTIC TESTING

NOTE: Testing listed below is not indicated for every condition. The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, even if in the past, 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 diagnoses of IVDS and 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.

19A. HAVE IMAGING STUDIES OF THE THORACOLUMBAR SPINE BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, IS ARTHRITIS DOCUMENTED?

☐ YES ☐ NO

19B. DOES THE VETERAN HAVE A VERTEBRAL FRACTURE?

☐ YES ☐ NO IF YES, PROVIDE PERCENT OF LOSS OF VERTEBRAL BODY HEIGHT: _____ %

19C. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS OR RESULTS?

☐ YES ☐ NO IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS *(brief summary)*:

19D. IF ANY TEST RESULTS ARE OTHER THAN NORMAL, INDICATE RELATIONSHIP OF ABNORMAL FINDINGS TO DIAGNOSED CONDITIONS:

SECTION XX - FUNCTIONAL IMPACT

NOTE: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

20. REGARDLESS OF THE VETERAN'S CURRENT EMPLOYMENT STATUS, DO THE CONDITION(S) LISTED IN THE DIAGNOSIS SECTION IMPACT HIS OR HER ABILITY TO PERFORM ANY TYPE OF OCCUPATIONAL TASK *(such as standing, walking, lifting, sitting, etc.)*?

☐ YES ☐ NO IF YES, DESCRIBE THE FUNCTIONAL IMPACT OF EACH CONDITION, PROVIDING ONE OR MORE EXAMPLES:

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SECTION XXI - REMARKS

21. REMARKS, IF ANY:

SECTION XXII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

22A. PHYSICIAN'S SIGNATURE	22B. PHYSICIAN'S PRINTED NAME	22C. DATE SIGNED

22D. PHYSICIAN'S PHONE AND FAX NUMBER	22E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	22F. 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, 58/VA21/22/28, 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 30 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.