	Explication Base. Alternation						
Department of Veterans Affairs	FIBROMYALGIA 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 BEFORE COMPLETING FORM.							
NAME OF PATIENT/VETERAN (First, Middle Initial, Last)							
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						
NOTE - Fibromyalgia may also be called fibrositis or primary fibromy. 1A DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER BEEN DI	Algia syndrome. IAGNOSED WITH FIBROMYALGIA? (This is the condition the veteran is claiming or for which an						
exam has been requested)	WONGOLD WITT IBROWN NEGRAL (This is the containon the veteral is claiming or for which an						
YES NO (If "Yes," complete Item 1B)							
NOTE : These are the diagnoses determined during this current evaluation from a previous diagnosis for this condition, or if there is a diagnosis of section. Date of diagnosis can be the date of the evaluation if the clinicial reported history.	on of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different a complication due to the claimed condition, explain your findings and reasons in the "Remarks" an is making the initial diagnosis, or an appropriate date determined through record review or						
1B. SELECT THE VETERAN'S CONDITION (check all that apply)							
	DATE OF DIAGNOSIS:						
OTHER (specify)							
OTHER DIAGNOSIS #1 ICD CODE:	DATE OF DIAGNOSIS:						
OTHER DIAGNOSIS #2 ICD CODE:	DATE OF DIACNOSIS						
1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO FIBR	DATE OF DIAGNOSIS:						
0_000	II - MEDICAL RECORD REVIEW						
2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARATION OF THE COLORS	HIS REPORT:						
C-FILE (VA ONLY) OTHER (Describe):							
	ION III - MEDICAL HISTORY						
3A. DESCRIBE THE HISTORY (including onset and course) OF THE VE	TERAN'S FIBROMYALGIA CONDITION:						
3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF FIB							
YES NO (If "Yes," list only those medications required for	or the veteran's fibromyalgia condition):						
3C. IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR	THIS CONDITION?						
YES NO (If "Yes," describe):							
3D. ARE THE VETERAN'S FIBROMYALGIA SYMPTOMS REFRACTORY	TO THERAPY?						
YES NO (If "Yes," describe):							

SECTION IV - FINDINGS, SIGNS, SYMPTOMS A DOES THE VETERAN CURRENITY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO FIROMYALGIA? TES	PATIENT/VETERAN'S SOCIAL SECURITY NO.		-						
VES		SECTION IV - FINDIN	IGS, SIGNS, SYMPT	OMS					
WIDESPREAD MUSCULOSKELETAL PAIN (NOTE: For VA purposes widespread miscalaskeletal pain means that pain occurs in both sides of the hody, but above and below the winst and affecting both the catal skeleton (i.e., cervical spine, unierior chest, thereace spine or low back) and the extremities) STEPRESS MUSCUE WEANNESS STEPRESS MUSCUE WEANNESS PATISITY PATISI	<u></u>								
abree and below the vasts and affecting both the axial skeleton (i.e., cervical spine, anterior chest, thoracic spine or low back) and the extremities) STIFFESS MUSCLE WEAKNESS FATIGUE SLEEP DISTURBANCES PARESTHESIAS HEADACHE DEPRESSION ANNETY OFFERSION ANNETY OFFER (discrebb): (For all checked conditions, describe) ANDETY OFFER (discrebb): (For all checked conditions, describe) ANDETY OFFER (discrebb): (For all checked conditions, describe) (For all checked conditions) (For all checked condi	YES NO (If "Yes," complete items 4B & 4C)								
NOTE - If Mental Health conditions, such as depression due to fibromyalgia are identified, a VA Form 21-0960P-2, Mental Disorders (Other than PTSD) Disabili Renefits Questionnaire must ALSO be completed. B. FREQUENCY OF FIBROMYALGA SYMPTOMS (check all that apply) \[\text{NO SYMPTOMS} \] \[\text{PISODIC WITH EXACERBATIONS} \] \[\text{PRESENT MORE THAN ONE-THIRD OF THE TIME} \] \[\text{CONSTANT OR NEARLY CONSTANT} \] \[OFTEN PRECIPITATED BY ENVIRONMENTAL OR EMOTIONAL STRESS OR OVEREXERTION (If checked, describe):	WIDESPREAD MUSCULOSKELETAL PA above and below the waist and affecting STIFFNESS MUSCLE WEAKNESS FATIGUE SLEEP DISTURBANCES PARESTHESIAS HEADACHE DEPRESSION ANXIETY IRRITABLE BOWEL SYMPTOMS RAYNAUD'S-LIKE SYMPTOMS	IN (NOTE: For VA purposes wides							
NOTE - If Mental Health conditions, such as depression due to fibromyalgia are identified, a VA Form 21-0960P-2, Mental Disorders (Other than PTSD) Disabili Renefits Questionnaire must ALSO be completed. B. FREQUENCY OF FIBROMYALGA SYMPTOMS (check all that apply) \[\text{NO SYMPTOMS} \] \[\text{PISODIC WITH EXACERBATIONS} \] \[\text{PRESENT MORE THAN ONE-THIRD OF THE TIME} \] \[\text{CONSTANT OR NEARLY CONSTANT} \] \[OFTEN PRECIPITATED BY ENVIRONMENTAL OR EMOTIONAL STRESS OR OVEREXERTION (If checked, describe):	(For all checked conditions, describe)								
AB. FREQUENCY OF FIBROMYALGIA SYMPTOMS (check all that apply) NO SYMPTOMS EPISODIC WITH EXACERBATIONS PRESENT MORE THAN ONE-THIRD OF THE TIME CONSTANT OR NEARLY CONSTANT OFTEN PRECIPITATED BY ENVIRONMENTAL OR EMOTIONAL STRESS OR OVEREXERTION (If checked, describe): THER (describe): 4C. TENDER POINTS (trigger points) FOR PAIN (check all that apply) None All bilaterally Low covical region: at anterior aspect of the interspaces between ransverse processes of C5-C7 (If checked, indicate side): Second five at second costochondral junction (If checked, indicate side): Right Left Both Cociput: at suboccipital muscle insertion (If checked, indicate side): Supraspinatus Muscle: above medial border of the scapular spine (If checked, indicate side): Gluteal: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Creater trochanter: posterior to greater trochanteric prominence (If checked, indicate side): Right Left Both Greater trochanter: posterior to greater trochanteric prominence (If checked, indicate side): Right Left Both Knee: medial joint line (If checked, indicate side): Right Left Both Knee: medial joint line (If checked, indicate side): SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS 5. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS? YES NO (If "Yes." describe - brief summary):	NOTE - If Mental Health conditions, such as d		identified, a VA Form 2	1-0960P-2, Mental Disorders (Other than PTSD) Disability	_				
NO SYMPTOMS									
AC. TENDER POINTS (trigger points) FOR PAIN (check all that apply) None	EPISODIC WITH EXACERBATIONS PRESENT MORE THAN ONE-THIRD OF CONSTANT OR NEARLY CONSTANT		R OVEREXERTION (If	checked, describe):	_				
None All bilaterally Low cervical region: at anterior aspect of the interspaces between transverse processes of C5-C7 (If checked, indicate side):	OTHER (describe):				_				
All bilaterally Low cervical region: at anterior aspect of the interspaces between transverse processes of C5-C7 (If checked, indicate side): Right Left Both Both Cociput: at suboccipital muscle insertion (If checked, indicate side): Right Left Both Cociput: at suboccipital muscle insertion (If checked, indicate side): Right Left Both Cociput: at suboccipital muscle insertion (If checked, indicate side): Right Left Both Cociput: at suboccipital muscle insertion (If checked, indicate side): Right Left Both Cociput: at suboccipital muscle insertion (If checked, indicate side): Right Left Both Cociput: at supper outer diagrams of the scapular spine (If checked, indicate side): Right Left Both Cociput: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Cociput: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Cociput: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Cociput: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Cociput: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Cociput: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Cociput: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Cociput: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Cociput: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Cociput: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Cociput: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Cociput: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Cociput: at upper outer quadrant of buttocks (If checked, indicate side): Right Left Both Cociput:	4C. TENDER POINTS (trigger points) FOR PAIN	\(\) (check all that apply)			=				
5. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS? YES NO (If "Yes," describe - brief summary): SECTION VI - DIAGNOSTIC TESTING NOTE - If diagnostic test results are in the medical record and reflect the veteran's current condition, repeat testing is not required.	All bilaterally Low cervical region: at anterior aspect of the transverse processes of C5-C7 (If checked Second rib: at second costochondral junction of the company of the cost of the transverse processes of C5-C7 (If checked Second rib: at second costochondral junction of the cost of the cost of transverse processes of C5-C7 (If checked Second rib: at second costochondral junction of the cost of transverse processes of C5-C7 (If checked second rib: at	d, indicate side): on (If checked, indicate side): of checked, indicate side): or (If checked, indicate side): or of the scapular spine (If checked, indicate side): of the scapular spine (If checked, indicate side): of (If checked, indicate side): others (If checked, indicate): others (If checked, indicate):	dicate side):	Right Left Both					
CONDITIONS LISTED IN SECTION I, DIAGNOSIS? YES NO (If "Yes," describe - brief summary): SECTION VI - DIAGNOSTIC TESTING NOTE - If diagnostic test results are in the medical record and reflect the veteran's current condition, repeat testing is not required.	SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS								
NOTE - If diagnostic test results are in the medical record and reflect the veteran's current condition, repeat testing is not required.	5. DOES THE VETERAN HAVE ANY OTHER PE CONDITIONS LISTED IN SECTION I, DIAGNO	RTINENT PHYSICAL FINDINGS, C DSIS?							
	SECTION VI - DIAGNOSTIC TESTING								
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)):	6. ARE THERE ANY SIGNIFICANT DIAGNOSTIC	C TEST FINDINGS AND/OR RESUL	TS?						

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PATIENT/VETERAN'S SOCIAL SECURITY NO.	-	- -						
SECTION VII - FUNCTIONAL IMPACT								
7. DOES THE VETERAN'S FIBROMYALGIA IMPACT HIS OR HER ABILITY TO WORK?								
YES NO (If "Yes," describe im			vide one or more o	examples)				
		SECTION VIII - R	EMARKS					
	SECTION IX - P	HYSICIAN'S CERTII	FICATION AND	SIGNATURE				
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/FAX NUMBERS		OVIDER IDENTIFIER (N		9F. PHYSICIAN'S ADDRI				
NOTE - VA may obtain 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 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 low 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 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.

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