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

Name of Patient/Veteran	Patient/Veteran's Social Security Number	Date of examination:

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.

Note - The Veteran 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 may obtain additional medical information, including an examination, if necessary, to complete VA's review of the Veteran's application. VA reserves the right to confirm the authenticity of ALL completed questionnaires. **It is intended that this questionnaire will be completed by the Veteran's healthcare provider.**

Are you completing this Disability Benefits Questionnaire at the request of:

☐ Veteran/Claimant

☐ Third party (please list name(s) of organization(s) or individual(s))

☐ Other: please describe

Are you a VA Healthcare provider? ◯ Yes ◯ No

Is the Veteran regularly seen as a patient in your clinic? ◯ Yes ◯ No

Was the Veteran examined in person? ◯ Yes ◯ No

If no, how was the examination conducted?

EVIDENCE REVIEW

Evidence reviewed:

◯ No records were reviewed

◯ Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

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)

1B. Select the Veteran's condition: (check all that apply)

☐ CNS infections: ICD code: _____ 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: _____ Date of diagnosis: _____

- ☐ Thrombosis, TIA or cerebral infarction
- ☐ Hemorrhage (specify type): _____
- ☐ Cerebral arteriosclerosis
- ☐ Other (specify): _____

☐ Hydrocephalus: ICD code: _____ Date of diagnosis: _____

- ☐ Obstructive
- ☐ Communicating
- ☐ Normal pressure (NPH)

☐ Brain tumor: ICD code: _____ Date of diagnosis: _____

☐ Spinal cord conditions: ICD code: _____ 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: _____ Date of diagnosis: _____

- ☐ Bulbar palsy
- ☐ Pseudobulbar palsy
- ☐ Other (specify): _____

☐ Movement disorders: ICD code: _____ 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: _____ Date of diagnosis: _____

- ☐ Progressive Muscular atrophy
- ☐ Myasthenia gravis
- ☐ Myasthenic syndrome
- ☐ Botulism
- ☐ Hereditary muscular disorders (specify): _____
- ☐ Familial periodic paralysis
- ☐ Myoglobinuria
- ☐ Dermatomyositis or polymyositis (specify): _____
- ☐ Other (specify): _____

☐ Intoxications: ICD code: _____ 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)

2B. Does the Veteran's central nervous system condition 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 DUE TO CNS CONDITION

3A. Does the Veteran report any muscle weakness in the upper and/or lower extremities attributable to a CNS condition?

◯ Yes ◯ No

(If "Yes," document under strength testing in neurologic exam section)

3B. Does the Veteran have any pharynx and/or larynx and/or swallowing conditions attributable to a CNS condition?

◯ 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

☐ Dysphagia (difficulty swallowing)

☐ Requiring daily medication to control dysphagia

☐ Documented history of esophageal stricture(s) attributable to CNS condition (see Note 1) (If checked indicate if recurrent or refractory)

Note 1: Findings must be documented by barium swallow, computerized tomography (CT), or esophagogastroduodenoscopy (EGD). (Indicate date of study in the Remarks section.)

Has the esophageal stricture(s) been recurrent or refractory? (see Note 2)

Note 2: Recurrent esophageal stricture is defined as the inability to maintain target esophageal diameter beyond 4 weeks after the target diameter has been achieved. Refractory esophageal stricture is defined as the inability to achieve target esophageal diameter despite receiving no fewer than 5 dilatation sessions performed at 2-week intervals.

◯ Yes ◯ No

☐ Without daily symptoms

☐ Without requirement for daily medications

☐ Requiring dilatation (if checked indicate frequency and list most recent dates):

◯ No more than 2 times a year ◯ 3 or more times a year

Was there dilatation utilizing steroids at least 1 time per year?

◯ Yes ◯ No

Date of dilatation: _____ Date of dilatation: _____ Date of dilatation: _____

☐ Requiring esophageal stent placement

☐ Treatment with surgical correction

☐ Aspiration

☐ Undernutrition (see Note 3)

☐ Substantial weight loss (see Note 4)

☐ Treatment with a percutaneous esophago-gastrointestinal tube (PEG tube)

☐ Other, symptom(s) specify:

_____

Note 3: "Undernutrition" means a deficiency resulting from insufficient intake of one or multiple essential nutrients, or the inability of the body to absorb, utilize, or retain such nutrients. Undernutrition is characterized by failure of the body to maintain normal organ functions and healthy tissues. Signs and symptoms may include: loss of subcutaneous tissue, edema, peripheral neuropathy, muscle wasting, weakness, abdominal distention, ascites, and Body Mass Index below normal range.

Note 4: "Substantial weight loss" means involuntary loss greater than 20 percent of an individual's baseline weight sustained for three months with diminished quality of self-care or work tasks. "Baseline weight" means the clinically documented average weight for the two-year period preceding the onset of illness or, if relevant, the weight recorded at the Veteran's most recent discharge physical. If neither of these weights is available or currently relevant, then use ideal body weight as determined by either the Hamwi formula or Body Mass Index tables, whichever is most favorable to the Veteran.

3C. Does the Veteran report any respiratory conditions attributable to a CNS condition?

◯ Yes ◯ No

(If "Yes," provide PFT results under "Diagnostic Testing" Section)

3D. Does the Veteran have sleep disturbances attributable to a CNS condition?

◯ 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, etc.

☐ Sleep apnea causing chronic respiratory failure with carbon dioxide retention or cor pulmonale

☐ Sleep apnea requiring tracheostomy

Note: Complete or partial loss of sphincter control refers to the inability to retain or expel stool at an appropriate time and place.

3E. Does the Veteran have impairment of sphincter control attributable to a CNS condition?

◯ Yes ◯ No If "Yes," indicate severity:

◯ History of loss of sphincter control, currently asymptomatic

◯ Complete loss of sphincter control

◯ Partial loss of sphincter control

3F. Does the Veteran report bowel incontinence to solids and/or liquids attributable to a CNS condition?

◯ Yes ◯ No If "Yes," indicate frequency:

◯ Less than once every six months, which requires wearing a pad at least once every six months

◯ At least once every six months, which requires wearing a pad at least once every six months

◯ Two or more times per month, which requires wearing a pad two or more times per month

◯ Two or more times per week, which requires wearing a pad two or more times per week

◯ Two or more times per day, which requires changing a pad two or more times per day

3G. Does the Veteran have a physician-prescribed bowel program?

◯ Yes ◯ No If "Yes," indicate responsiveness:

◯ Fully responsive

◯ Partially responsive

◯ Not responsive

Indicate the bowel program requirements (Check all that apply)

☐ Special diet

☐ Medication If checked, are there prescribed medication(s) beyond laxative use?

◯ Yes ◯ No

☐ Digital stimulation

☐ Surgery

If checked, provide the date of surgery or anticipated date of surgery:

☐ Other, please describe:

3H. Does the Veteran report gastrointestinal symptoms attributable to a CNS condition?

◯ Yes ◯ No If "Yes," check all that apply

☐ Change in stool frequency ☐ Change in stool form ☐ Altered stool passage (straining and/or urgency) ☐ Mucorrhea

☐ Abdominal bloating ☐ Subjective distention ☐ Constipation

☐ Other (specify): _____

☐ Abdominal pain related to defecation (if checked, indicate frequency during the previous 3 months)

◯ None ◯ At least once ◯ At least 3 days per month ◯ At least 1 day per week

3I. Does the Veteran report voiding dysfunction causing urine leakage attributable to a CNS condition?

◯ Yes ◯ No (If "Yes," check all that apply)

☐ 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

3J. Does the Veteran report voiding dysfunction causing signs and/or symptoms of urinary frequency attributable to a CNS condition?

◯ Yes ◯ No (If "Yes," check all that apply)

◯ Daytime voiding interval greater than 3 hours ◯ Nighttime awakening to void less than 2 times

◯ Daytime voiding interval between 2 and 3 hours ◯ Nighttime awakening to void 2 times

◯ Daytime voiding interval between 1 and 2 hours ◯ Nighttime awakening to void 3 to 4 times

◯ Daytime voiding interval less than 1 hour ◯ Nighttime awakening to void 5 or more times

3K. Does the Veteran have voiding dysfunction causing findings, or report signs and/or symptoms of obstructed voiding attributable to a CNS condition?

◯ 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 10cc/sec

☐ Post void residuals greater than 150 cc

☐ Urinary retention requiring intermittent or continuous catheterization

3L. Does the Veteran have voiding dysfunction requiring the use of an appliance attributable to a CNS condition?

◯ Yes ◯ No (If "Yes," describe appliance):

3M. Does the Veteran have a history of recurrent symptomatic urinary tract infections attributable to a CNS condition?

◯ Yes ◯ No

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

☐ No treatment

☐ Suppressive drug therapy

◯ Lasting 6 months or longer ◯ For less than 6 months

☐ Hospitalization

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

☐ Drainage by stent or nephrostomy tube

☐ Continuous intensive management required

☐ Other management/treatment not listed above (Description of management/treatment including dates of treatment):

For all options checked above, list medications/management/treatments used for urinary tract infection and indicate dates for courses of treatment over the past 12 months:

3N. Does the Veteran report erectile dysfunction or female sexual arousal disorder (FSAD) attributable to a CNS condition?

Note: Female Sexual Arousal Disorder (FSAD) refers to the continual or recurrent physical inability of a woman to accomplish or maintain an ample lubrication-swelling reaction during sexual intercourse. Decreased blood flow to the genital area is believed to contribute to FSAD similar to the role of vascular disease in male erectile dysfunction. Other causes may include nerve and/or tissue damage.

◯ 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

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: _____

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 ◯ Complete (no remaining function) ☐ With atrophy

Left upper extremity muscle weakness:

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Complete (no remaining function) ☐ With atrophy

Right lower extremity muscle weakness:

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Complete (no remaining function) ☐ With atrophy

Left lower extremity muscle weakness:

◯ None ◯ Mild ◯ Moderate ◯ Severe ◯ Complete (no remaining function) ☐ With atrophy

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 in the Diagnosis section?

◯ 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 the Diagnosis section, describe using the above format:

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

6A. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms related to the conditions listed in the Diagnosis section above?

◯ Yes ◯ No

If yes, describe (brief summary):

6B. 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", also complete the appropriate dermatological questionnaire)

6C. Comments, if any:

SECTION VII - MENTAL HEALTH MANIFESTATIONS DUE TO A 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 condition and/or its treatment?

◯ Yes ◯ No

(If "Yes," also complete the Mental Disorders Disability Benefits Questionnaire (schedule with appropriate provider))

SECTION VIII - DIFFERENTIATION OF SYMPTOMS OR NEUROLOGIC EFFECTS

8A. Are you able to differentiate what portion of the symptomatology or neurologic effects above are 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

9A. 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, indicate the side, and identify the assistive device used for each condition.

SECTION X - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

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.

10A. 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 Veteran'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 clinically relevant diagnostic imaging studies or other diagnostic procedures been performed or reviewed in conjunction with this examination?

◯ 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: _____

FVC: _____ % 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 clinically relevant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

◯ Yes ◯ No

If yes, provide type of test or procedure, date and results (brief summary): _____

SECTION XII - FUNCTIONAL IMPACT

12A. 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

13A. Remarks (if any - please identify the section to which the remark pertains when appropriate).

SECTION XIV - EXAMINER'S CERTIFICATION AND SIGNATURE

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

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false, or for the fraudulent acceptance of any payment to which you are not entitled.

14A. Examiner's signature:	14B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

14C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	14D. Date Signed:

14E. Examiner's phone/fax numbers:	14F. National Provider Identifier (NPI) number:	14G. Medical license number and state:

14H. Examiner's address: