



## 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

58

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

57

**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:

59

IF NO, CHECK ALL RECORDS REVIEWED:

- |  |   |
|--|---|
| <input checked="" 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: 61  |
| <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:

60

**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*):

- |  |              |                       |
|--|--------------|-----------------------|
| <input type="checkbox"/> The Veteran does not have a current diagnosis associated with any claimed condition listed above. ( <i>Explain your findings and reasons in comments section.</i> ) |              |                       |
| <input type="checkbox"/> Mechanical back pain syndrome   | ICD Code: 33 | Date of diagnosis: 32 |
| <input type="checkbox"/> Lumbosacral sprain/strain   | ICD Code: 30 | Date of diagnosis: 31 |
| <input type="checkbox"/> Facet joint arthropathy ( <i>degenerative joint disease of lumbosacral spine</i> )  | ICD Code: 29 | Date of diagnosis: 28 |
| <input type="checkbox"/> Degenerative disc disease   | ICD Code: 26 | Date of diagnosis: 27 |
| <input type="checkbox"/> Degenerative scoliosis  | ICD Code: 3  | Date of diagnosis: 2  |
| <input type="checkbox"/> Foraminal/lateral recess/central stenosis   | ICD Code: 25 | Date of diagnosis: 24 |
| <input type="checkbox"/> Degenerative spondylolisthesis  | ICD Code: 22 | Date of diagnosis: 23 |
| <input type="checkbox"/> Spondylolysis/isthmic spondylolisthesis   | ICD Code: 21 | Date of diagnosis: 20 |
| <input type="checkbox"/> Intervertebral disc syndrome  | ICD Code: 18 | Date of diagnosis: 19 |
| <input type="checkbox"/> Radiculopathy   | ICD Code: 15 | Date of diagnosis: 14 |
| <input type="checkbox"/> Ankylosis of thoracolumbar spine  | ICD Code: 10 | Date of diagnosis: 11 |
| <input type="checkbox"/> Ankylosing spondylitis of the thoracolumbar spine ( <i>back</i> )   | ICD Code: 9  | Date of diagnosis: 8  |

**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.

- |  |             |                      |
|--|-------------|----------------------|
| <input type="checkbox"/> Vertebral fracture ( <i>vertebrae of the back</i> ) | ICD Code: 4 | Date of diagnosis: 5 |
|--|-------------|----------------------|

☐ Other (*specify*)

Other diagnosis #1: 62

ICD Code: 16 Date of diagnosis: 17

**SECTION I - DIAGNOSIS (Continued)**

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

Other diagnosis #2: 106ICD Code: 104 Date of diagnosis: 103Other diagnosis #3: 105ICD Code: 101 Date of diagnosis: 102

1C. COMMENTS (if any):

100

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):

65

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:

66

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:

67**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:
84  BACK	Forward Flexion (normal endpoint = 90 degrees)	<u>96</u> <input checked="" type="checkbox"/> Not indicated <input checked="" type="checkbox"/> Not able to perform	<u>97</u>
	Extension (normal endpoint = 30 degrees)	<u>86</u> <input checked="" type="checkbox"/> Not indicated <input checked="" type="checkbox"/> Not able to perform	<u>98</u>
	Right Lateral Flexion (normal endpoint = 30 degrees)	<u>90</u> <input checked="" type="checkbox"/> Not indicated <input checked="" type="checkbox"/> Not able to perform	<u>99</u>
	Left Lateral Flexion (normal endpoint = 30 degrees)	<u>87</u> <input checked="" type="checkbox"/> Not indicated <input checked="" type="checkbox"/> Not able to perform	<u>77</u>
	Right Lateral Rotation (normal endpoint = 30 degrees)	<u>82</u> <input checked="" type="checkbox"/> Not indicated <input checked="" type="checkbox"/> Not able to perform	<u>75</u>
	Left Lateral Rotation (normal endpoint = 30 degrees)	<u>78</u> <input checked="" type="checkbox"/> Not indicated <input checked="" type="checkbox"/> Not able to perform	<u>76</u>

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

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

☐110 YES (you will be asked to further describe these limitations in Section 7 below)☐109 NO, EXPLAIN WHY THE ABNORMAL ROMs DO NOT CONTRIBUTE:

108

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:

107

**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"/> 115 Yes If yes, perform repetitive-use testing	<input type="checkbox"/> 118 Yes	Forward Flexion	<input type="text"/> 112
<input type="checkbox"/> 116 No If no, provide reason below, then proceed to Section 5	<input type="checkbox"/> 117 No, there is no change in ROM after repetitive testing	Extension	<input type="text"/> 111
	If yes, report ROM after a minimum of 3 repetitions.	Left Lateral Flexion	<input type="text"/> 113
	If no, documentation of ROM after repetitive-use testing is not required.	Right Lateral Flexion	<input type="text"/> 114
		Left Lateral Rotation	<input type="text"/> 120
		Right Lateral Rotation	<input type="text"/> 121

119

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

☐124 YES (you will be asked to further describe these limitations in Section 7 below)☐123 NO, EXPLAIN WHY THE POST-TEST ADDITIONAL LIMITATIONS OF ROMs DO NOT CONTRIBUTE:

122

**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:
<input type="checkbox"/> 125 Yes <input type="checkbox"/> 126 No	<input type="checkbox"/> 127 Yes (you will be asked to further describe these limitations in Section 7 below) <input type="checkbox"/> 128 No	

129

**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:
<input type="checkbox"/> 134 Yes <input type="checkbox"/> 133 No	<input type="checkbox"/> 132 Yes (you will be asked to further describe these limitations in Section 7 below) <input type="checkbox"/> 131 No	

130

**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"/> 135 Yes <input type="checkbox"/> 136 No	

137

5D. COMMENTS, IF ANY:

138

**SECTION VI - GUARDING AND MUSCLE SPASM**6A. DOES THE VETERAN HAVE GUARDING OR MUSCLE SPASM OF THE THORACOLUMBAR SPINE (*back*)?☐152 YES ☐151 NO

6B. GAIT:

☐145 NORMAL☐146 ABNORMAL

Due to:

☐147 Muscle spasm☐148 Guarding☐150 Other, describe and provide etiology:

153

☐149 UNABLE TO EVALUATE, PROVIDE REASON:

154

6C. SPINAL CONTOUR:

☐144 NORMAL☐143 ABNORMAL

Due to:

☐142 Muscle spasm☐141 Guarding☐140 Other, describe and provide etiology:

139

☐155 UNABLE TO EVALUATE, PROVIDE REASON:

156

**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*):☐159 Less movement than normal (*due to ankylosis, limitation or blocking, adhesions, tendon-tie-ups, contracted scars, etc.*)☐164 More movement than normal (*from flail joints, resections, nonunion of fractures, relaxation of ligaments, etc.*)☐158 Weakened movement (*due to muscle injury, disease or injury of peripheral nerves, divided or lengthened tendons, etc.*)☐157 Excess fatigability☐171 Incoordination, impaired ability to execute skilled movements smoothly☐170 Pain on movement☐169 Swelling☐168 Deformity☐167 Atrophy of disuse☐160 Instability of station☐163 Disturbance of locomotion☐161 Interference with sitting☐162 Interference with standing☐166 Other, describe:

165

# **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 <b><i>used repeatedly over a period of time</i></b> ?	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:
<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	Forward Flexion <input type="text" value="184"/> <input type="checkbox"/> Est. ROM is not feasible	<input type="text" value="188"/>
	Extension <input type="text" value="185"/> <input type="checkbox"/> Est. ROM is not feasible	
	Right Lateral Flexion <input type="text" value="174"/> <input type="checkbox"/> Est. ROM is not feasible	
	Left Lateral Flexion <input type="text" value="180"/> <input type="checkbox"/> Est. ROM is not feasible	
	Right Lateral Rotation <input type="text" value="175"/> <input type="checkbox"/> Est. ROM is not feasible	
	Left Lateral Rotation <input type="text" value="177"/> <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:

189

## **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:
201  RIGHT	Hip Flexion	<input type="text" value="199"/> /5	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input checked="" type="checkbox"/> Yes <input type="checkbox"/> No	<input type="text" value="200"/>
	Knee Flexion	<input type="text" value="192"/> /5			
	Knee Extension	<input type="text" value="193"/> /5			
	Ankle Plantar Flexion	<input type="text" value="198"/> /5			
	Ankle Dorsiflexion	<input type="text" value="197"/> /5			
	Foot Abduction	<input type="text" value="194"/> /5			
	Foot Adduction	<input type="text" value="195"/> /5			
	Great Toe Extension	<input type="text" value="196"/> /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:
228  LEFT	Hip Flexion	226 /5	229 Yes 230 No	232 Yes 231 No	227
	Knee Flexion	219 /5			
	Knee Extension	220 /5			
	Ankle Plantar Flexion	225 /5			
	Ankle Dorsiflexion	224 /5			
	Foot Abduction	221 /5			
	Foot Adduction	222 /5			
	Great Toe Extension	223 /5			

**8B. DOES THE VETERAN HAVE MUSCLE ATROPHY?**

206 YES 207 NO

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

208 YES 209 NO IF NO, PROVIDE RATIONALE:

210

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:

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

213

CIRCUMFERENCE OF MORE NORMAL SIDE: 212 CM CIRCUMFERENCE OF ATROPHIED SIDE: 211 CM

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

216

CIRCUMFERENCE OF MORE NORMAL SIDE: 215 CM CIRCUMFERENCE OF ATROPHIED SIDE: 217 CM

**8C. COMMENTS, IF ANY:**

233

**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:**

238 Favorable ankylosis of the entire thoracolumbar spine

237 Unfavorable ankylosis of the entire thoracolumbar spine

236 Unfavorable ankylosis of the entire spine (cervical and thoracolumbar)

235 No ankylosis

**9B. COMMENTS, IF ANY:**

234

**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: 240

KNEE: 244<sup>+</sup> ANKLE: 241<sup>+</sup>

LEFT: 239

KNEE: 242<sup>+</sup> ANKLE: 243<sup>+</sup>

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

10B. COMMENTS, IF ANY:

337

# **SECTION XI - SENSORY EXAM**

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

Side	Upper Anterior Thigh ( <i>L2</i> )		Thigh/Knee ( <i>L3/4</i> )		Lower Leg/Ankle ( <i>L4/L5/S1</i> )		Foot/Toes ( <i>L5</i> )	
RIGHT	<input type="checkbox"/> 310 Normal	<input type="checkbox"/> 269 Decreased	<input type="checkbox"/> 288 Normal	<input type="checkbox"/> 290 Decreased	<input type="checkbox"/> 287 Normal	<input type="checkbox"/> 285 Decreased	<input type="checkbox"/> 275 Normal	<input type="checkbox"/> 277 Decreased
335		<input type="checkbox"/> 309 Absent		<input type="checkbox"/> 289 Absent		<input type="checkbox"/> 286 Absent		<input type="checkbox"/> 276 Absent
LEFT	<input type="checkbox"/> 270 Normal	<input type="checkbox"/> 284 Decreased	<input type="checkbox"/> 274 Normal	<input type="checkbox"/> 272 Decreased	<input type="checkbox"/> 281 Normal	<input type="checkbox"/> 283 Decreased	<input type="checkbox"/> 280 Normal	<input type="checkbox"/> 278 Decreased
336		<input type="checkbox"/> 271 Absent		<input type="checkbox"/> 273 Absent		<input type="checkbox"/> 282 Absent		<input type="checkbox"/> 279 Absent

11B. WERE OTHER SENSORY TESTS INDICATED AND PERFORMED?

☐313 YES ☐314 NO

IF YES, INDICATE RESULTS:

Side	Position Sense ( <i>grasp great toe on sides and ask patient to identify up and down movement</i> )			Vibration Sensation ( <i>place low-pitched tuning fork over IP joint of great toe</i> )			Cold Sensation ( <i>test distal extremities for cold sensation with side of tuning fork or other cold object</i> )		
	<input type="checkbox"/> 315 Not tested			<input type="checkbox"/> 312 Not tested			<input type="checkbox"/> 311 Not tested		
RIGHT	<input type="checkbox"/> 291 Normal	<input type="checkbox"/> 307 Decreased	<input type="checkbox"/> 308 Absent	<input type="checkbox"/> 306 Normal	<input type="checkbox"/> 305 Decreased	<input type="checkbox"/> 304 Absent	<input type="checkbox"/> 301 Normal	<input type="checkbox"/> 302 Decreased	<input type="checkbox"/> 303 Absent
LEFT	<input type="checkbox"/> 300 Normal	<input type="checkbox"/> 293 Decreased	<input type="checkbox"/> 292 Absent	<input type="checkbox"/> 294 Normal	<input type="checkbox"/> 295 Decreased	<input type="checkbox"/> 296 Absent	<input type="checkbox"/> 299 Normal	<input type="checkbox"/> 298 Decreased	<input type="checkbox"/> 297 Absent

11C. OTHER SENSORY FINDINGS, IF ANY:

256

# **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: ☐317 NEGATIVE ☐318 POSITIVE ☐319 UNABLE TO PERFORM

LEFT: ☐320 NEGATIVE ☐321 POSITIVE ☐322 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?

☐316 YES ☐334 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:

257

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

☐323 Present ☐329 Absent (*does not occur*) ☐330 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: ☐326 None ☐325 Mild ☐324 Moderate ☐327 Severe

Left lower extremity: ☐331 None ☐332 Mild ☐333 Moderate ☐328 Severe

13C. INTERMITTENT PAIN (*subjective symptom*)

☐268 Present ☐262 Absent (*does not occur*) ☐261 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: ☐265 None ☐266 Mild ☐267 Moderate ☐264 Severe

Left lower extremity: ☐260 None ☐259 Mild ☐258 Moderate ☐263 Severe

13D. DULL PAIN (*subjective symptom*)

☐245 Present ☐251 Absent (*does not occur*) ☐252 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: ☐248 None ☐247 Mild ☐246 Moderate ☐249 Severe

Left lower extremity: ☐253 None ☐254 Mild ☐255 Moderate ☐250 Severe

**SECTION XIII - RADICULOPATHY (Continued)****13E. PARESTHESIAS AND/OR DYSESTHESIAS** *(subjective symptom)*

☒357 Present ☒363 Absent *(does not occur)* ☒364 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: ☒360 None ☒359 Mild ☒358 Moderate ☒361 Severe

Left lower extremity: ☒365 None ☒366 Mild ☒367 Moderate ☒362 Severe

**13F. NUMBNESS** *(subjective symptom)*

☒356 Present ☒350 Absent *(does not occur)* ☒349 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: ☒353 None ☒354 Mild ☒355 Moderate ☒352 Severe

Left lower extremity: ☒348 None ☒347 Mild ☒338 Moderate ☒351 Severe

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

☒381 YES ☒368 NO

IF YES, DESCRIBE:

382

**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: ☒341 Not affected ☒340 Mild ☒339 Moderate ☒342 Severe

Left lower extremity: ☒344 Not affected ☒345 Mild ☒346 Moderate ☒343 Severe

**13I. SPECIFY NERVE ROOTS INVOLVED** *(check all that apply):*☒369 INVOLVEMENT OF L2/L3/L4 NERVE ROOTS *(femoral nerve)*

If checked, indicate side affected: ☒384 Right ☒383 Left ☒385 Both

☒380 INVOLVEMENT OF L4/L5/S1/S2/S3 NERVE ROOTS *(sciatic nerve)*

If checked, indicate side affected: ☒378 Right ☒379 Left ☒377 Both

☒370 OTHER NERVES *(specify nerve root involved):*

387  
If checked, indicate side affected: ☒372 Right ☒371 Left ☒373 Both

**13J. DOMINANT HAND**

☒374 RIGHT ☒375 LEFT ☒376 AMBIDEXTROUS

**13K. COMMENTS, IF ANY:**

386

**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?

☒399 YES ☒398 NO

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

388

**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?**

☒389 YES ☒390 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?

☒391 YES ☒397 NO

**15C. IF YES TO QUESTION 15B ABOVE, PROVIDE THE TOTAL DURATION OF ALL INCAPACITATING EPISODES OVER THE PAST 12 MONTHS:**

☒392 Less than 1 week

☒396 At least 1 week but less than 2 weeks

☒393 At least 2 weeks but less than 4 weeks

☒394 At least 4 weeks but less than 6 weeks

☒395 At least 6 weeks



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

15D. COMMENTS, IF ANY:

441

**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?☒ 409 YES ☒ 408 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?

☒ 402 YES ☒ 403 NO IF YES, DESCRIBE (*brief summary*):

401

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?☒ 404 YES ☒ 405 NOIF 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?☒ 406 YES ☒ 407 NO IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

IF NO, PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.

Location: ☒ 410 \_\_\_\_\_ Measurements: length ☒ 411 \_\_\_\_\_ cm X width ☒ 412 \_\_\_\_\_ 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:

400

**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?

☒ 414 YES ☒ 415 NO IF YES, IDENTIFY ASSISTIVE DEVICES USED (*check all that apply and indicate frequency*):

<input checked="" type="checkbox"/> 432 Wheelchair	Frequency of use:	<input checked="" type="checkbox"/> 431 Occasional	<input checked="" type="checkbox"/> 430 Regular	<input checked="" type="checkbox"/> 429 Constant
<input checked="" type="checkbox"/> 416 Brace	Frequency of use:	<input checked="" type="checkbox"/> 434 Occasional	<input checked="" type="checkbox"/> 438 Regular	<input checked="" type="checkbox"/> 439 Constant
<input checked="" type="checkbox"/> 428 Crutches	Frequency of use:	<input checked="" type="checkbox"/> 427 Occasional	<input checked="" type="checkbox"/> 426 Regular	<input checked="" type="checkbox"/> 425 Constant
<input checked="" type="checkbox"/> 417 Cane	Frequency of use:	<input checked="" type="checkbox"/> 422 Occasional	<input checked="" type="checkbox"/> 423 Regular	<input checked="" type="checkbox"/> 424 Constant
<input checked="" type="checkbox"/> 421 Walker	Frequency of use:	<input checked="" type="checkbox"/> 420 Occasional	<input checked="" type="checkbox"/> 419 Regular	<input checked="" type="checkbox"/> 418 Constant
<input checked="" type="checkbox"/> 433 Other: <input checked="" type="checkbox"/> 440 _____	Frequency of use:	<input checked="" type="checkbox"/> 437 Occasional	<input checked="" type="checkbox"/> 436 Regular	<input checked="" type="checkbox"/> 435 Constant

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

413

**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.*)☒ 446 YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROSTHESIS WOULD EQUALLY SERVE THE VETERAN.☒ 445 NOIF YES, INDICATE EXTREMITIES FOR WHICH THIS APPLIES: ☒ 443 RIGHT LOWER ☒ 444 LEFT LOWERFOR EACH CHECKED EXTREMITY, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, DESCRIBE LOSS OF EFFECTIVE FUNCTION AND PROVIDE SPECIFIC EXAMPLES (*brief summary*):

442

**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.

**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?

☒ 454 YES ☒ 453 NO

IF YES, IS ARTHRITIS DOCUMENTED?

☒ 447 YES ☒ 448 NO

19B. DOES THE VETERAN HAVE A VERTEBRAL FRACTURE?

☒ 449 YES ☒ 450 NO IF YES, PROVIDE PERCENT OF LOSS OF VERTEBRAL BODY HEIGHT:  460 %

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

☒ 451 YES ☒ 452 NO IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS (*brief summary*):

455

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

456

**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.*)?

☒ 459 YES ☒ 458 NO IF YES, DESCRIBE THE FUNCTIONAL IMPACT OF EACH CONDITION, PROVIDING ONE OR MORE EXAMPLES:

457

## SECTION XXI - REMARKS

21. REMARKS, IF ANY:

461

## 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

468

465

464

22D. PHYSICIAN'S PHONE NUMBER

22E. PHYSICIAN'S MEDICAL LICENSE NUMBER

22F. PHYSICIAN'S ADDRESS

467

466

463

**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 462  
(VA Regional Office FAX No.)**NOTE:** A list of VA Regional Office FAX Numbers can be found at [www.vba.va.gov/disabilityexams](http://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](http://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.