Department of Veterans Affairs

BACK (THORACOLUMBAR SPINE) CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

Name of Claimant/Veteran	Claimant/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 questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider.**

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

☐ Veteran/Claimant

☐ 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

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 questionnaire:

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 the remarks 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 conditions listed above. (Explain your findings and reasons in the remarks section)

☐ Ankylosing spondylitis	ICD Code: _____	Date of diagnosis: _____
☐ Degenerative arthritis	ICD Code: _____	Date of diagnosis: _____
☐ Degenerative disc disease other than intervertebral disc syndrome (IVDS)	ICD Code: _____	Date of diagnosis: _____
☐ Lumbosacral strain	ICD Code: _____	Date of diagnosis: _____
☐ Intervertebral disc syndrome (Note: See VA definition of IVDS in Section XI.)	ICD Code: _____	Date of diagnosis: _____
☐ Sacroiliac injury	ICD Code: _____	Date of diagnosis: _____
☐ Sacroiliac weakness	ICD Code: _____	Date of diagnosis: _____
☐ Segmental instability	ICD Code: _____	Date of diagnosis: _____
☐ Spinal fusion	ICD Code: _____	Date of diagnosis: _____
☐ Spinal stenosis	ICD Code: _____	Date of diagnosis: _____
☐ Spondylolisthesis	ICD Code: _____	Date of diagnosis: _____
☐ Traumatic paralysis, complete	ICD Code: _____	Date of diagnosis: _____
☐ Vertebral dislocation	ICD Code: _____	Date of diagnosis: _____
☐ Vertebral fracture	ICD Code: _____	Date of diagnosis: _____
☐ 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. If there are additional diagnoses pertaining to thoracolumbar spine conditions, list using above format:

SECTION II - MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's thoracolumbar spine condition (brief summary):

2B. Does the Veteran report flare-ups of the thoracolumbar spine?

☐ Yes ☐ No

If yes, document the Veteran's description of the flare-ups he/she experiences, including the frequency, duration, characteristics, precipitating and alleviating factors, severity, and/or extent of functional impairment he/she experiences during a flare-up of symptoms:

SECTION II - MEDICAL HISTORY

2C. Does the Veteran report having any functional loss or functional impairment of the joint or extremity being evaluated on this questionnaire, including but not limited to after repeated use over time?

☐ Yes ☐ No

If yes, document the Veteran's description of functional loss or functional impairment in his/her own words.

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION

There are several separate parameters requested for describing function of a joint. The question "Does this ROM contribute to a functional loss?" asks if there is a functional loss that can be ascribed to any documented loss of range of motion; and, unlike later questions, does not take into account the numerous other factors to be considered. Subsequent questions take into account additional factors such as pain, fatigue, weakness, lack of endurance, or incoordination. If there is pain noted on examination, it is important to understand whether or not that pain itself contributes to functional loss. Ideally, a claimant would be seen immediately after repetitive use over time or during a flare-up; however, this is not always feasible.

Information regarding joint function on repetitive use is broken up into two subsets. The first subset is based on observed repetitive use, and the second is based on functional loss associated with repeated use over time. The observed repetitive use section initially asks for objective findings after three or more repetitions of range of motion testing. The second subset provides a more global picture of functional loss associated with repetitive use over time. The latter takes into account medical probability of additional functional loss as a global view. This takes into account not only the objective findings noted on the examination, but also the subjective history provided by the claimant, as well as review of the available medical evidence.

Optimally, a description of any additional loss of function should be provided - such as what the degrees of range of motion would be opined to look like after repetitive use over time. However, when this is not feasible, an "as clear as possible" description of that loss should be provided. This same information (minus the three repetitions) is asked to be provided with regards to flare-ups.

3A. Initial ROM measurements

☐ All Normal ☐ Abnormal or outside of normal range

☐ Unable to test ☐ Not indicated

If "Unable to test" or "Not indicated," please explain:

If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than a back condition, such as age, body habitus, neurologic disease), please describe:

If abnormal, does the range of motion itself contribute to a functional loss? ☐ Yes ☐ No

If yes, please explain:

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION (continued)

Note: For any joint condition, examiners should address pain on both passive and active motion, and on both weight-bearing and nonweight-bearing. If testing cannot be performed or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation must be given below. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).

Can testing be performed? ☐ Yes ☐ No

If no, provide an explanation:

Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values.

Forward flexion endpoint (90 degrees): _____ degrees		Left lateral flexion endpoint (30 degrees): _____ degrees	
Extension endpoint (30 degrees): _____ degrees		Right lateral rotation endpoint (30 degrees): _____ degrees	
Right lateral flexion endpoint (30 degrees): _____ degrees		Left lateral rotation endpoint (30 degrees): _____ degrees	

If noted on examination, which ROM exhibited pain (select all that apply):

☐ Forward flexion	☐ Right lateral flexion	☐ Right lateral rotation
☐ Extension	☐ Left lateral flexion	☐ Left lateral rotation

If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.

Forward flexion: _____ Degree endpoint (if different than above)		Left lateral flexion: _____ Degree endpoint (if different than above)	
Extension: _____ Degree endpoint (if different than above)		Right lateral rotation: _____ Degree endpoint (if different than above)	
Right lateral flexion: _____ Degree endpoint (if different than above)		Left lateral rotation: _____ Degree endpoint (if different than above)	

Passive Range of Motion - Perform passive range of motion and provide the ROM values.

Was passive range of motion testing performed? ☐ Yes ☐ No If not, indicate why passive range of motion testing was not performed:

☐ Medically contraindicated (e.g., it may cause the Veteran severe pain or the risk of further injury). It is not medically advisable to conduct passive range of motion testing because (provide explanation).

☐ Testing not necessary because (provide explanation).

☐ Other (provide explanation).

Explanation:

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION (continued)

Forward flexion endpoint (90 degrees):	_____	degrees	☐ Same as active ROM
Extension endpoint (30 degrees):	_____	degrees	☐ Same as active ROM
Right lateral flexion endpoint (30 degrees):	_____	degrees	☐ Same as active ROM
Left lateral flexion endpoint (30 degrees):	_____	degrees	☐ Same as active ROM
Right lateral rotation endpoint (30 degrees):	_____	degrees	☐ Same as active ROM
Left lateral rotation endpoint (30 degrees):	_____	degrees	☐ Same as active ROM

If noted on examination, which passive ROM exhibited pain (select all that apply):

☐ Forward flexion ☐ Right lateral flexion ☐ Right lateral rotation
☐ Extension ☐ Left lateral flexion ☐ Left lateral rotation

If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.

Forward flexion:	_____	Degree endpoint (if different than above)	Left lateral flexion:	_____	Degree endpoint (if different than above)
Extension:	_____	Degree endpoint (if different than above)	Right lateral rotation:	_____	Degree endpoint (if different than above)
Right lateral flexion:	_____	Degree endpoint (if different than above)	Left lateral rotation:	_____	Degree endpoint (if different than above)

Is there evidence of pain? ☐ Yes ☐ No If yes check all that apply:

☐ Weight-bearing ☐ Nonweight-bearing ☐ Active motion ☐ Passive motion ☐ On rest/non-movement

☐ Causes functional loss (if checked describe in the comments box below) ☐ Does not result in/cause functional loss

Comments:

Is there objective evidence of crepitus? ☐ Yes ☐ No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? ☐ Yes ☐ No

If yes, describe location, severity, and relationship to condition(s):

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION (continued)

3B. Observed repetitive use ROM

Is the Veteran able to perform repetitive use testing with at least three repetitions? ☐ Yes ☐ No

If no, please explain:

Is there additional loss of function or range of motion after three repetitions? ☐ Yes ☐ No

If yes, please respond to the following after completion of the three repetitions:

Forward flexion endpoint (90 degrees): _____ degrees		Left lateral flexion endpoint (30 degrees): _____ degrees	
Extension endpoint (30 degrees): _____ degrees		Right lateral rotation endpoint (30 degrees): _____ degrees	
Right lateral flexion endpoint (30 degrees): _____ degrees		Left lateral rotation endpoint (30 degrees): _____ degrees	

Select all factors that cause this functional loss: (check all that apply) ☐ N/A ☐ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance ☐ Incoordination ☐ Other:

Note: When pain is associated with movement, the examiner must give a statement on whether pain could significantly limit functional ability during flare-ups and/or after repeated use over time in terms of additional loss of range of motion. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare-ups - even if not directly observed during a flare-up and/or after repeated use over time.

3C. Repeated use over time

Is the Veteran being examined immediately after repeated use over time? ☐ Yes ☐ No

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time? ☐ Yes ☐ No

Select all factors that cause this functional loss: (check all that apply) ☐ N/A ☐ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance ☐ Incoordination ☐ Other:

Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran:

Forward flexion endpoint (90 degrees): _____ degrees		Left lateral flexion endpoint (30 degrees): _____ degrees	
Extension endpoint (30 degrees): _____ degrees		Right lateral rotation endpoint (30 degrees): _____ degrees	
Right lateral flexion endpoint (30 degrees): _____ degrees		Left lateral rotation endpoint (30 degrees): _____ degrees	

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence):

3D. Flare-ups

Is the Veteran being examined during a flare-up? ☐ Yes ☐ No

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare-ups? ☐ Yes ☐ No

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION (continued)

Select all factors that cause this functional loss: (check all that apply)

☐ N/A ☐ Pain ☐ Fatigability ☐ Weakness ☐ Lack of endurance ☐ Incoordination

☐ Other:

Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran:

Forward flexion endpoint (90 degrees):	_____ degrees	Left lateral flexion endpoint (30 degrees):	_____ degrees
Extension endpoint (30 degrees):	_____ degrees	Right lateral rotation endpoint (30 degrees):	_____ degrees
Right lateral flexion endpoint (30 degrees):	_____ degrees	Left lateral rotation endpoint (30 degrees):	_____ degrees

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence):

3E. Guarding and muscle spasm

Does the Veteran have localized tenderness, guarding or muscle spasm of the thoracolumbar spine?

☐ Yes ☐ No

Localized tenderness:

☐ None

☐ Not resulting in abnormal gait or abnormal spinal contour

Provide description and/or etiology:

Muscle spasm:

☐ None

☐ Resulting in abnormal gait or abnormal spine contour

☐ Not resulting in abnormal gait or abnormal spinal contour

☐ Unable to evaluate, describe below:

Provide description and/or etiology:

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION (continued)

Guarding:

- ☐ None
- ☐ Resulting in abnormal gait or abnormal spine contour
- ☐ Not resulting in abnormal gait or abnormal spinal contour
- ☐ Unable to evaluate, describe below:

Provide description and/or etiology:

3F. Additional factors contributing to disability

In addition to those addressed above, are there additional contributing factors of disability? Please select all that apply and describe:

☐ None	☐ Interference with sitting	☐ Interference with standing	☐ Swelling	☐ Deformity
☐ Disturbance of locomotion	☐ Less movement than normal	☐ More movement than normal	☐ Weakened movement	☐ Atrophy of disuse
☐ Instability of station	☐ Other, describe:			

Please describe additional contributing factors of disability:

SECTION IV - MUSCLE STRENGTH TESTING

4A. 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	Flexion/ Extension	Rate Strength	Side	Flexion/ Extension	Rate Strength	Flexion/ Extension	Rate Strength
Right	Hip Flexion	/5	Ankle Dorsiflexion	/5	Left	Hip Flexion	/5	Ankle Dorsiflexion	/5
All Normal	Knee Extension	/5	Great Toe Extension	/5	All Normal	Knee Extension	/5	Great Toe Extension	/5
	Ankle Plantar Flexion	/5				Ankle Plantar Flexion	/5		

4B. Does the Veteran have muscle atrophy?

☐ Yes ☐ No

SECTION IV - MUSCLE STRENGTH TESTING (continued)

4C. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section?

☐ Yes ☐ No

If no, provide rationale:

4D. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.

Provide measurements in centimeters of normal side and atrophied side, measured at maximum muscle bulk.

Circumference of normal side: _____ cm Circumference of atrophied side: _____ cm

SECTION V - REFLEX EXAM

5A. 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: +

SECTION VI - SENSORY EXAM

6A. Provide 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

Other sensory findings, if any:

SECTION VII - 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.

7A. Provide straight leg raising test results:

Right: ☐ Negative ☐ Positive ☐ Unable to perform

Left: ☐ Negative ☐ Positive ☐ Unable to perform

If "Unable to perform," please explain:

SECTION VIII - RADICULOPATHY

Note: 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. Electromyography (EMG) studies are rarely required to diagnose radiculopathy in the appropriate clinical setting.

Does the Veteran have radicular pain or any other signs or symptoms due to radiculopathy?

☐ Yes ☐ No If yes, complete sections 8A - 8D.

8A. Indicate symptoms' location and severity (check all that apply):

Note: For VA purposes, when the involvement is wholly sensory, the evaluation should be for the mild, or at the most, the moderate degree.

Constant pain (may be excruciating at times):	Right lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
	Left lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Intermittent pain (usually dull):	Right lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
	Left lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Paresthesias and/or dysesthesias:	Right lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
	Left lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
Numbness:	Right lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe
	Left lower extremity:	☐ None	☐ Mild	☐ Moderate	☐ Severe

8B. Does the Veteran have any other signs or symptoms of radiculopathy?

☐ Yes ☐ No

If yes, describe:

8C. Indicate 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 and side(s) affected):
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both

SECTION VIII - RADICULOPATHY (continued)

8D. For any abnormal or positive identified neurological findings identified in Sections 4-8, explain the likely cause of those identified symptoms:

SECTION IX - ANKYLOSIS

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 (zero degrees) always represents favorable ankylosis.

9A. Is there ankylosis of the spine?

☐ Yes ☐ No If yes, indicate severity of ankylosis:

☐ Unfavorable ankylosis of the entire spine ☐ Unfavorable ankylosis of the entire thoracolumbar spine ☐ Favorable ankylosis of the entire thoracolumbar spine

9B. Comments, if any:

SECTION X - OTHER NEUROLOGIC ABNORMALITIES

10A. Does the Veteran have any other neurologic abnormalities or findings (other than those identified in Sections 4 - 8) related to a thoracolumbar spine condition (such as bowel or bladder problems/pathologic reflexes)?

☐ Yes ☐ No

If yes, describe condition and how it is related:

Note: If there are neurological abnormalities other than radiculopathy, also complete appropriate questionnaire for each condition identified.

SECTION XI - INTERVERTEBRAL DISC SYNDROME (IVDS) AND EPISODES REQUIRING BED REST

Note: IVDS is a group of signs and symptoms due to disc herniation with compression and/or irritation of the adjacent nerve root 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. Imaging studies are not required to make the diagnosis of IVDS.

11A. Does the Veteran have IVDS of the thoracolumbar spine?

☐ Yes ☐ No

11B. If yes to question 11A above, has the Veteran had any episodes of acute signs and symptoms due to IVDS that required bed rest prescribed by a physician and treatment by a physician in the past 12 months?

☐ Yes ☐ No

If yes select the total duration over the past 12 months:

- ☐ With no episodes of bed rest during the past 12 months
- ☐ With episodes of bed rest having a total duration of at least 1 week but less than 2 weeks during the past 12 months
- ☐ With episodes of bed rest having a total duration of at least 2 weeks but less than 4 weeks during the past 12 months
- ☐ With episodes of bed rest having a total duration of at least 4 weeks but less than 6 weeks during the past 12 months
- ☐ With episodes of bed rest having a total duration of at least 6 weeks during the past 12 months

SECTION XI - INTERVERTEBRAL DISC SYNDROME (IVDS) AND EPISODES REQUIRING BED REST (continued)

11C. If yes to question 11B above, provide the following documentation that supports the yes response:

☐ Medical history as described by the Veteran only, without documentation:

☐ Medical history as shown and documented in the Veteran's file.
Individual date(s) of each treatment record(s) reviewed:

Facility/provider:

Describe treatment:

☐ Other, describe:

SECTION XII - ASSISTIVE DEVICES

12A. 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

12B. If the Veteran uses any assistive devices, specify the condition, indicate the side, and identify the assistive device used for each condition.

SECTION XIII - 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.

13A. Due to the Veteran's thoracolumbar spine 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 extremities for which this applies: ☐ Right lower ☐ Left lower ☐ Right upper ☐ Left upper

For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

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

14A. 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):

14B. Does the Veteran have any scars or other disfigurement of the skin related to any conditions or to the treatment of any conditions listed in the diagnosis section?

☐ Yes ☐ No

If yes, complete appropriate dermatological questionnaire.

14C. Comments, if any:

SECTION XV - DIAGNOSTIC TESTING

Note: Testing listed below is not indicated for every condition. The diagnosis of degenerative arthritis (osteoarthritis) or post-traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, 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.

15A. Have imaging studies been performed in conjunction with this examination?

☐ Yes ☐ No

15B. If yes, is degenerative or post-traumatic arthritis documented?

☐ Yes ☐ No

15C. If yes, provide type of test or procedure, date and results (brief summary):

15D. Does the Veteran have imaging evidence of a thoracolumbar vertebral fracture with loss of 50 percent or more of height?

☐ Yes ☐ No ☐ N/A

15E. Are there any other significant 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):

15F. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

SECTION XVI - 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.

16A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/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:

SECTION XVII - REMARKS

17A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

SECTION XVIII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

18A. Examiner's signature:

18B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):

18C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):

18D. Date Signed:

18E. Examiner's phone/fax numbers:

18F. National Provider Identifier (NPI) number:

18G. Medical license number and state:

18H. Examiner's address: