

Compensation and Pension Record Interchange (CAPRI)

CAPRI Compensation and Pension Worksheet Module (CPWM)

Templates and AMIE Worksheet Disability Benefits Questionnaires (DBQs)

Release Notes

Patch: DVBA\*2.7\*167

June 2011

Department of Veterans Affairs

Office of Enterprise Development

Management & Financial Systems

**Preface**

**Purpose of the Release Notes**

The Release Notes document describes the new features and functionality of patch DVBA\*2.7\*167. (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs).

The information contained in this document is not intended to replace the CAPRI User Manual. The CAPRI User Manual should be used to obtain detailed information regarding specific functionality.

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# Purpose

The purpose of this document is to provide an overview of the enhancements specifically designed

for Patch DVBA\*2.7\*167.

Patch DVBA \*2.7\*167 (CAPRI CPWM TEMPLATES AND AMIE WORKSHEET DBQs)

introduces enhancements and updates made to the AUTOMATED MED INFO EXCHANGE

(AMIE) V 2.7 package and the Compensation & Pension Record Interchange (CAPRI) application

in support of the new Compensation and Pension (C&P) Disability Benefits Questionnaires (DBQs).

# Overview

Veterans Benefits Administration Veterans Affairs Central Office (VBAVACO) has approved implementation of the following new Disability Benefits Questionnaires:

* **DBQ AMYOTROPHIC LATERAL SCLEROSIS (LOU GEHRIG'S DISEASE)**
* **DBQ BACK (THORACOLUMBAR SPINE) CONDITIONS**
* **DBQ NECK (CERVICAL SPINE) CONDITIONS**
* **DBQ PERIPHERAL NERVES (NOT INCLUDING DIABETIC SENSORY- MOTOR PERIPHERAL NEUROPATHY)**

# Associated Remedy Tickets & New Service Requests

There are no Remedy tickets or New Service Requests associated with patch DVBA\*2.7\*167.

# Defects Fixes

There are no CAPRI DBQ Templates or AMIE – DBQ Worksheet defects fixes associated with

patch DVBA\*2.7\*167.

# Enhancements

This section provides an overview of the modifications and primary functionality that will be

delivered in Patch DVBA\*2.7\*167.

## CAPRI – DBQ Template Additions

This patch includes adding four new CAPRI DBQ Templates that are accessible through the

Compensation and Pension Worksheet Module (CPWM) of the CAPRI GUI application.

* **DBQ AMYOTROPHIC LATERAL SCLEROSIS (LOU GEHRIG'S DISEASE)**
* **DBQ BACK (THORACOLUMBAR SPINE) CONDITIONS**
* **DBQ NECK (CERVICAL SPINE) CONDITIONS**
* **DBQ PERIPHERAL NERVES CONDITIONS (NOT INCLUDING DIABETIC**

**SENSORY – MOTOR PERIPHERAL NEUROPATHY)**

## CAPRI – DBQ Template Modifications

There are no CAPRI DBQ Templates Modifications associated with patch DVBA\*2.7\*167.

## AMIE–DBQ Worksheet Additions

VBAVACO has approved the following new AMIE –DBQ Worksheets that are accessible through

the Veterans Health Information Systems and Technology Architecture (VistA) AMIE software

package.

* **DBQ AMYOTROPHIC LATERAL SCLEROSIS (LOU GEHRIG'S DISEASE)**
* **DBQ BACK (THORACOLUMBAR SPINE) CONDITIONS**
* **DBQ NECK (CERVICAL SPINE) CONDITIONS**
* **DBQ PERIPHERAL NERVES (EXCLUDING DIABETIC NEUROPATHY)**

This patch implements the new content for the AMIE C&P Disability Benefit Questionnaire

worksheets, which are accessible through the VISTA AMIE software package.

## AMIE–DBQ Worksheet Modifications

There are no CAPRI AMIE – DBQ Worksheets modifications associated with patch DVBA\*2.7\*167.

# Disability Benefits Questionnaires (DBQs)

The following section illustrates the content of the new questionnaires included in Patch DVBA\*2.7\*167.

## 6.1. DBQ Amyotrophic Lateral Sclerosis (Lou Gehrig’s disease)

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.**

**VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran’s claim.**

**1. Diagnosis**

Does the Veteran now have or has he/she ever been diagnosed with Amyotrophic Lateral Sclerosis (ALS)?

Yes  No

If yes, provide only diagnoses that pertain to ALS:

Diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #3 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there are additional diagnoses that pertain to ALS, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s ALS (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_

b. Dominant hand

Right  Left  Ambidextrous

**3. Conditions, signs and symptoms due to ALS**

a. Does the Veteran have any muscle weakness in the upper and/or lower extremities attributable to ALS?

Yes  No

If yes, report under strength testing in neurologic exam section.

b. Does the Veteran have any pharynx and/or larynx and/or swallowing conditions attributable to ALS?

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

Mild swallowing difficulties

Moderate swallowing difficulties

Severe swallowing difficulties, permitting passage of liquids only

Requires feeding tube due to swallowing difficulties

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Does the Veteran have any respiratory conditions attributable to ALS?

Yes  No

If yes, provide PFT results under “Diagnostic testing” section.

d. Does the Veteran have signs and/or symptoms of sleep apnea or sleep apnea-like condition attributable

to ALS?

NOTE: If signs and/or symptoms of sleep apnea or sleep apnea-like condition are due to ALS, these

symptoms are due to weakness in the palatal, pharyngeal, laryngeal, and/or respiratory musculature. A

sleep study is not indicated to report symptoms of sleep apnea or sleep apnea-like conditions that are

attributable to ALS.

Yes  No

If yes, check all that apply:

Persistent daytime hypersomnolence

Requires use of breathing assistance device such as continuous airway pressure (CPAP) machine

Chronic respiratory failure with carbon dioxide retention or cor pulmonale

Requires tracheostomy

e. Does the Veteran have any bowel impairment attributable to ALS?

Yes  No

If yes, check all that apply:

Slight impairment of sphincter control, without leakage

Constant slight impairment of sphincter control, or occasional moderate leakage

Occasional involuntary bowel movements, necessitating wearing of a pad

Extensive leakage and fairly frequent involuntary bowel movements

Total loss of bowel sphincter control

Chronic constipation

Other bowel impairment (describe): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

f. Does the Veteran have voiding dysfunction causing urine leakage attributable to ALS?

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

g. Does the Veteran have voiding dysfunction causing signs and/or symptoms of urinary frequency attributable to ALS?

Yes  No

If yes, check all that apply:

Daytime voiding interval between 2 and 3 hours

Daytime voiding interval between 1 and 2 hours

Daytime voiding interval less than 1 hour

Nighttime awakening to void 2 times

Nighttime awakening to void 3 to 4 times

Nighttime awakening to void 5 or more times

h. Does the Veteran have voiding dysfunction causing findings, signs and/or symptoms of obstructed

voiding attributable to ALS?

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 10 cc/sec

Post void residuals greater than 150 cc

Urinary retention requiring intermittent or continuous catheterization

i. Does the Veteran have voiding dysfunction requiring the use of an appliance attributable to ALS?

Yes  No

If yes, describe appliance: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

j. Does the Veteran have a history of recurrent symptomatic urinary tract infections attributable to ALS?

Yes  No

If yes, check all treatments that apply:

No treatment

Long-term drug therapy

If checked, list medications used for urinary tract infection and indicate dates for courses of treatment over

the past 12 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitalization

If checked, indicate frequency of hospitalization:

1 or 2 per year

More than 2 per year

Drainage

If checked, indicate dates when drainage performed over past 12 months: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other management/treatment not listed above

Description of management/treatment including dates of treatment: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

k. Does the Veteran (if male) have erectile dysfunction?

Yes  No

If yes, is the erectile dysfunction as likely as not (at least a 50% probability) attributable to ALS?

Yes  No

If no, provide the etiology of the erectile dysfunction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If yes, is the Veteran able to achieve an erection (without medication) sufficient for penetration and

ejaculation?

Yes  No

If no, is the Veteran able to achieve an erection (with medication) sufficient for penetration

and ejaculation?

Yes  No

**4. Neurologic exam**

a. Speech

Normal  Abnormal

If speech is abnormal, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. 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: \_\_\_\_\_\_\_\_

c. 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

d. 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+

e. Plantar (Babinski) reflex

Right:  plantar flexion (normal, or negative Babinski)

dorsiflexion (abnormal, or positive Babinski)

Left:  plantar flexion (normal, or negative Babinski)

dorsiflexion (abnormal, or positive Babinski)

f. Does the Veteran have muscle atrophy attributable to ALS?

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.

g. Summary of muscle weakness in the upper and/or lower extremities attributable to ALS (check all that apply):

Right upper extremity muscle weakness:

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

Left upper extremity muscle weakness:

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

Right lower extremity muscle weakness:

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

Left lower extremity muscle weakness:

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

NOTE: 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: \_\_\_\_\_\_\_\_\_\_\_\_\_

**5. Other pertinent physical findings, complications, conditions, signs and/or symptoms**

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of

any conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or

symptoms related to ALS?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**6. Mental health manifestations due to ALS or its treatment**

Does the Veteran have depression, cognitive impairment or dementia, or any other mental disorder

attributable to ALS and/or its treatment?

Yes  No

If yes, does the Veteran’s mental disorder, as identified in the question above, result in gross impairment in

thought processes or communication?

Yes  No

Also complete a Mental Disorder Questionnaire (schedule with appropriate provider).

If yes, briefly describe the Veteran’s mental disorder: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Housebound**

a. Is the Veteran substantially confined to his or her dwelling and the immediate premises (or if

institutionalized, to the ward or clinical areas)?

Yes  No

If yes, describe how often per day or week and under what circumstances the Veteran is able to leave the

home or immediate premises: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. If yes, does the Veteran have more than one condition contributing to his or her being housebound?

Yes  No

If yes, list conditions and describe how each condition contributes to causing the Veteran to be housebound:

Condition #1: \_\_\_\_\_\_\_\_\_\_\_\_

Describe how condition #1 contributes to causing the Veteran to be housebound: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition #2: \_\_\_\_\_\_\_\_\_\_\_\_

Describe how condition #2 contributes to causing the Veteran to be housebound: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Condition #3: \_\_\_\_\_\_\_\_\_\_\_\_

Describe how condition #3 contributes to causing the Veteran to be housebound: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. If the Veteran has additional conditions contributing to causing the Veteran to be housebound, list using

above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Aid & Attendance**

a. Is the Veteran able to dress or undress him or herself without assistance?

Yes  No

If no, is this limitation caused by the Veteran’s ALS?

Yes  No

b. Does the Veteran have sufficient upper extremity coordination and strength to be able to feed him or

herself without assistance?

Yes  No

If no, is this limitation caused by the Veteran’s ALS?

Yes  No

c. Is the Veteran able to attend to the wants of nature (toileting) without assistance?

Yes  No

If no, is this limitation caused by the Veteran’s ALS?

Yes  No

d. Is the Veteran able to bathe him or herself without assistance?

Yes  No

If no, is this limitation caused by the Veteran’s ALS?

Yes  No

e. Is the Veteran able to keep him or herself ordinarily clean and presentable without assistance?

Yes  No

If no, is this limitation caused by the Veteran’s ALS?

Yes  No

f. Does the Veteran need frequent assistance for adjustment of any special prosthetic or orthopedic

appliance(s)?

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

NOTE: For VA purposes, “bedridden” will be that condition which actually requires that the claimant remain

in bed. The fact that claimant has voluntarily taken to bed or that a physician has prescribed rest in bed for

the greater or lesser part of the day to promote convalescence or cure will not suffice.

g. Is the Veteran bedridden?

Yes  No

If yes, is it due to the Veteran’s ALS?

Yes  No

h. Does the Veteran require care and/or assistance on a regular basis due to his or her physical and/or

mental disabilities in order to protect him or herself from the hazards and/or dangers incident to his or her

daily environment?

Yes  No

If yes, is it due to the Veteran’s ALS?

Yes  No

i. List any condition(s), in addition to the Veteran’s ALS, that causes any of the above limitations: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Need for higher level (i.e., more skilled) Aid & Attendance (A&A)**

Does the Veteran requirea higher, more skilled level of A&A?

Yes  No

NOTE: For VA purposes, this skilled, higher level care includes (but is not limited to) health-care services

such as physical therapy, administration of injections, placement of indwelling catheters, changing of sterile

dressings, and/or like functions which require professional health-care training or the regular supervision of

a trained health-care professional to perform. In the absence of this higher level of care provided in the

home, the Veteran would require hospitalization, nursing home care, or other residential institutional care.

**10. Assistive devices**

a. 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

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used

for each condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11. Remaining effective function of the extremities**

Due to ALS 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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**12. Financial responsibility**

In your judgment, is the Veteran able to manage his/her benefit payments in his/her own best interest,

or able to direct someone else to do so?

Yes  No

If no, provide rationale: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**13. Diagnostic testing**

NOTE: 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 ALS.

a. Have PFTs been performed?

Yes  No

If yes, provide most recent results, if available:

FEV-1: \_\_\_\_\_\_\_\_\_\_\_\_ % predicted Date of test: \_\_\_\_\_\_\_\_\_\_\_\_\_

FVC: \_\_\_\_\_\_\_\_\_\_\_\_\_ % predicted Date of test: \_\_\_\_\_\_\_\_\_\_\_\_\_

FEV-1/FVC: \_\_\_\_\_\_\_ % predicted Date of test: \_\_\_\_\_\_\_\_\_\_\_\_\_

b. If PFTs have been performed, is the flow-volume loop compatible with upper airway obstruction?

Yes  No

c. Are there any other significant diagnostic test findings and/or results?

Yes  No

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

**14. Functional impact**

Does the Veteran’s ALS impact his or her ability to work?

Yes  No

If yes, describe the impact of the Veteran’s ALS, providing one or more examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**15. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to

complete VA’s review of the Veteran’s application.

## 6.2. DBQ Back (Thoracolumbar Spine) Conditions

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.  VA**

**will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran’s claim.**

**1. Diagnosis**

Does the Veteran now have or has he/she ever been diagnosed with a thoracolumbar spine (back)

condition?

Yes  No

If yes, provide only diagnoses that pertain to thoracolumbar spine (back) conditions:

Diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there are additional diagnoses pertaining to thoracolumbar spine (back) conditions, list using above

format: \_\_\_\_\_\_

**2. Medical history**

Describe the history (including onset and course) of the Veteran’s thoracolumbar spine (back) condition (brief

summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Flare-ups**

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: \_\_\_\_\_\_\_\_\_\_

**4. Initial range of motion (ROM) measurement:**

MeasureROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the

measurements, observe the point at which painful motion begins, evidenced by visible behavior such as facial

expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive-use testing. For VA purposes, repetitive-use

testing must be included in all exams. The VA has determined that 3 repetitions of ROM (at 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 section 5.

a. Select where forward flexion ends (normal endpoint is 90):

0 5 10 15 20 25 30 35 40 45

50  55 60 65 70 75 80 85 90 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40 45

50  55 60 65 70 75 80 85 90 or greater

b. Select where extension ends (normal endpoint is 30):

0 5 10 15 20 25 30 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 or greater

c. Select where right lateral flexion ends (normal endpoint is 30):

0 5 10 15 20 25 30 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 or greater

d. Select where left lateral flexion ends (normal endpoint is 30):

0 5 10 15 20 25 30 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 or greater

e. Select where right lateral rotation ends (normal endpoint is 30):

0 5 10 15 20 25 30 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 or greater

f. Select where left lateral rotation ends (normal endpoint is 30):

0 5 10 15 20 25 30 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 or greater

g. If ROM for this Veteran 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: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. ROM measurement after repetitive-use testing**

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?

Yes  No If unable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Veteran is unable to perform repetitive-use testing, skip to section 6.

If Veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions.

b. Select where post-test forward flexion ends:

0 5 10 15 20 25 30 35 40 45

50  55 60 65 70 75 80 85 90 or greater

c. Select wherepost-test extension ends:

0 5 10 15 20 25 30 or greater

d. Select where post-test right lateral flexion ends:

0 5 10 15 20 25 30 or greater

e. Select where post-test left lateral flexion ends:

0 5 10 15 20 25 30 or greater

f. Select where post-test right lateral rotation ends:

0 5 10 15 20 25 30 or greater

g. Select where post-test left lateral rotation ends:

0 5 10 15 20 25 30 or greater

**6. Functional loss and additional limitation in ROM**

The following section addresses reasons for functional loss, if present, and additional loss of ROM after

repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working

movements of the body with normal excursion, strength, speed, coordination and/or endurance.

a. Does the Veteran have additional limitation in ROM of the thoracolumbar spine (back) following repetitive

-use testing?

Yes  No

b. Does the Veteran have any functional loss and/or functional impairment of the thoracolumbar spine (back)?

Yes  No

c. If the Veteran has functional loss, functional impairment and/or additional limitation of ROM of the

thoracolumbar spine (back) after repetitive use, indicate the contributing factors of disability below:

Less movement than normal

More movement than normal

Weakened movement

Excess fatigability

In coordination, impaired ability to execute skilled movements smoothly

Pain on movement

Swelling

Deformity

Atrophy of disuse

Instability of station

Disturbance of locomotion

Interference with sitting, standing and /or weight-bearing

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Pain and muscle spasm (pain on palpation, effect of muscle spasm on gait)**

a. Does the Veteran have localized tenderness or pain to palpation for joints and/or soft tissue of the

thoracolumbar spine (back)?

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Does the Veteran have guarding or muscle spasm of the thoracolumbar spine (back)?

Yes  No

If yes, is it severe enough to result in: (check all that apply)

Abnormal gait

Abnormal spinal contour, such as scoliosis, reversed lordosis, or abnormal kyphosis

Guarding and/or muscle spasm is present, but do not result in abnormal gait or spinal contour

**8. Muscle strength testing**

a. 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

All normal

Hip 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

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

Great toe 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

b. Does the Veteran have muscle atrophy?

Yes  No

If muscle atrophy is present, indicate location: \_\_\_\_\_\_\_\_\_

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

Normal side: \_\_\_\_\_ cm. Atrophied side: \_\_\_\_\_ cm.

**9. Reflex exam**

Rate deep tendon reflexes (DTRs) according to the following scale:

0 Absent

1+ Hypoactive

2+ Normal

3+ Hyperactive without clonus

4+ Hyperactive with clonus

All normal

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+

**10. Sensory exam**

Provide results for sensation to light touch (dermatome) testing:

All normal

Upper anterior thigh (L2): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Thigh/knee (L3/4): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Lower leg/ankle (L4/L5/S1): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Foot/toes (L5): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Other sensory findings, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11. Straight leg raising test**

(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 in

the back or hamstrings. Pain is often increased on dorsiflexion of the foot, and relieved by knee flexion. A

positive test suggests radiculopathy, often due to disc herniation).

Provide straight leg raising test results:

Right:  Negative  Positive  Unable to perform

Left:  Negative  Positive  Unable to perform

**12. Radiculopathy**

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

Yes  No

If yes, complete the following section:

a. Indicate symptoms’ location and severity (check all that apply):

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

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

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Indicate nerve roots involved: (check all that apply)

Involvement of L2/L3L/L4 nerve roots (femoral nerve)

If checked, indicate:  Right  Left  Both

Involvement of L4/L5/S1/S2/S3 nerve roots (sciatic nerve)

If checked, indicate:  Right  Left  Both

Other nerves (specify nerve and side(s) affected): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

d. Indicate severity of radiculopathy and side affected:

Right:  Not affected  Mild  Moderate  Severe

Left:  Not affected  Mild  Moderate  Severe

**13. Other neurologic abnormalities**

Does the Veteran have any other neurologic abnormalities or findings related to a thoracolumbar spine (back)

condition (such as bowel or bladder problems/pathologic reflexes)?

Yes  No

If yes, describe condition and how it is related: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there are neurological abnormalities other than radiculopathy, also complete appropriate Questionnaire for

each condition identified.

**14. Intervertebral disc syndrome (IVDS) and incapacitating episodes**

a. Does the Veteran have IVDS of the thoracolumbar spine?

Yes  No

b. If yes, has the Veteran had any incapacitating episodes over the past 12 months due to IVDS?

Yes  No

NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require

prescribed bed rest and treatment by a physician.

If yes, provide the total duration of all incapacitating episodes over the past 12 months:

Less than 1 week

At least 1 week but less than 2 weeks

At least 2 weeks but less than 4 weeks

At least 4 weeks but less than 6 weeks

At least 6 weeks

**15. Assistive devices**

a. 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

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for

each condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**16. Remaining effective function of the extremities**

Due to a 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.; functions of 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 lower  Left lower

**17. Other pertinent physical findings, complications, conditions, signs and/or symptoms**

a. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any

conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39

square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or

symptoms?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**18. Diagnostic testing**

The diagnosis of arthritis must be confirmed by imaging studies. Once 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.

For purposes of this examination, the diagnosis of IVDS and/or 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.

a. Have imaging studies of the thoracolumbar spine been performed and are the results available?

Yes  No

If yes, is arthritis documented?

Yes  No

b. Does the Veteran have a vertebral fracture?

Yes  No

If yes, provide percent of loss of vertebral body: \_\_\_\_\_\_\_\_\_\_\_\_

c. Are there any other significant diagnostic test findings and/or results?

Yes  No

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

**19. Functional impact**

Does the Veteran’s thoracolumbar spine (back) condition impact on his or her ability to work?

Yes  No

If yes describe the impact of each of the Veteran’s thoracolumbar spine (back) conditions providing one or more examples\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**20. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to

complete VA’s review of the Veteran’s application.

## 6.3. DBQ Neck (Cervical Spine) Conditions

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.  VA**

**will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran’s claim.**

**1. Diagnosis**

Does the Veteran now have or has he/she ever been diagnosed with a cervical spine (neck) condition?

Yes  No

NOTE: Provide only diagnoses that pertain to cervical spine (neck) conditions.

Diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there are additional diagnoses that pertain to cervical spine (neck) conditions, list using above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**2. Medical history**

Describe the history (including onset and course) of the Veteran’s cervical spine (neck) condition (brief

summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**3. Flare-ups**

Does the Veteran report that flare-ups impact the function of the cervical spine (neck)?

Yes  No

If yes, document the Veteran’s description of the impact of flare-ups in his or her own words: \_\_\_\_\_\_\_\_\_\_

**4. Initial range of motion (ROM) measurements**

MeasureROM with a goniometer, rounding each measurement to the nearest 5 degrees. During the

measurements, observe the point at which painful motion begins, evidenced by visible behavior such as facial

expression, wincing, etc. Report initial measurements below.

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use

testing must be included in all exams. The VA has determined that 3 repetitions of ROM 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 section 5.

a. Select where forward flexion ends (normal endpoint is 45 degrees):

0 5 10 15 20 25 30 35 40 45 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40 45 or greater

b. Select where extension ends (normal endpoint is 45 degrees):

0 5 10 15 20 25 30 35 40 45 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40 45 or greater

c. Select where right lateral flexion ends (normal endpoint is 45 degrees):

0 5 10 15 20 25 30 35 40 45 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40 45 or greater

d. Select where left lateral flexion ends (normal endpoint is 45 degrees):

0 5 10 15 20 25 30 35 40 45 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40 45 or greater

e. Select where right lateral rotation ends (normal endpoint is 80 degrees):

0 5 10 15 20 25 30 35 40 45

50 55 60 65 70 75 80 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40 45

50 55 60 65 70 75 80 or greater

f. Select where left lateral rotation ends (normal endpoint is 80 degrees):

0 5 10 15 20 25 30 35 40 45

50 55 60 65 70 75 80 or greater

Select where objective evidence of painful motion begins:

No objective evidence of painful motion

0 5 10 15 20 25 30 35 40 45

50 55 60 65 70 75 80 or greater

g. If ROM does not conform to the normal range of motion identified above but is normal for this Veteran (for

reasons other than a cervical spine (neck) condition, such as age, body habitus, and neurologic disease), explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. ROM measurements after repetitive use testing**

a. Is the Veteran able to perform repetitive-use testing with 3 repetitions?

Yes  No If unable, provide reason: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If Veteran is unable to perform repetitive-use testing, skip to section 6.

If Veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions.

b. Select where post-test forward flexion ends:

0 5 10 15 20 25 30 35 40 45 or greater

c. Select where post-test extension ends:

0 5 10 15 20 25 30 35 40 45 or greater

d. Select where post-test right lateral flexion ends:

0 5 10 15 20 25 30 35 40 45 or greater

e. Select where post-test left lateral flexion ends:

0 5 10 15 20 25 30 35 40 45 or greater

f. Select where post-test right lateral rotation ends:

0 5 10 15 20 25 30 35 40 45

50 55 60 65 70 75 80 or greater

g. Select where post-test left lateral rotation ends:

0 5 10 15 20 25 30 35 40 45

50 55 60 65 70 75 80 or greater

**6. Functional loss and additional limitation in ROM**

The following section addresses reasons for functional loss, if present, and additional loss of ROM after

repetitive-use testing, if present. The VA defines functional loss as the inability to perform normal working

movements of the body with normal excursion, strength, speed, coordination and/or endurance.

a. Does the Veteran have additional limitation in ROM of the cervical spine (neck) following repetitive-use

testing?

Yes  No

b. Does the Veteran have any functional loss and/or functional impairment of the cervical spine (neck)?

Yes  No

c. If the Veteran has functional loss, functional impairment and/or additional limitation of ROM of the cervical

spine (neck) after repetitive use, indicate the contributing factors of disability below:

Less movement than normal

More movement than normal

Weakened movement

Excess fatigability

In coordination, impaired ability to execute skilled movements smoothly

Pain on movement

Swelling

Deformity

Atrophy of disuse

Instability of station

Disturbance of locomotion

Interference with sitting, standing and /or weight-bearing

Other, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Pain and muscle spasm (pain on palpation, effect of muscle spasm on gait)**

**a**. Does the Veteran have localized tenderness or pain to palpation for joints/soft tissue of the cervical spine

(neck)?

Yes  No

b. Does the Veteran have guarding or muscle spasm of the cervical spine (neck)?

Yes  No

If yes, is it severe enough to result in: (check all that apply)

Abnormal gait

Abnormal spinal contour

Guarding or muscle spasm is present, but do not result in abnormal gait or spinal contour

**8. Muscle strength testing**

a. 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

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

Finger 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

Finger Abduction 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

b. Does the Veteran have muscle atrophy?

Yes  No

If muscle atrophy is present, indicate location: \_\_\_\_\_\_\_\_\_

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

Normal side: \_\_\_\_\_ cm. Atrophied side: \_\_\_\_\_ cm.

**9. Reflex exam**

Rate deep tendon reflexes (DTRs) according to the following scale:

0 Absent

1+ Hypoactive

2+ Normal

3+ Hyperactive without clonus

4+ Hyperactive 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+

**10. Sensory exam**

Provide results for sensation to light touch (dermatomes) testing:

All normal

Shoulder area (C5): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Inner/outer forearm (C6/T1): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Hand/fingers (C6-8): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Other sensory findings, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**11. Radiculopathy**

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

Yes  No

If yes, complete the following section:

a. Indicate location and severity of symptoms (check all that apply):

Constant pain (may be excruciating at times)

Right upper extremity:  None  Mild  Moderate  Severe

Left upper extremity:  None  Mild  Moderate  Severe

Intermittent pain (usually dull)

Right upper extremity:  None  Mild  Moderate  Severe

Left upper extremity:  None  Mild  Moderate  Severe

Paresthesias and/or dysesthesias

Right upper extremity:  None  Mild  Moderate  Severe

Left upper extremity:  None  Mild  Moderate  Severe

Numbness

Right upper extremity:  None  Mild  Moderate  Severe

Left upper extremity:  None  Mild  Moderate  Severe

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

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

c. Indicate nerve roots involved: (check all that apply)

Involvement of C5/C6 nerve roots (upper radicular group)

Involvement of C7 nerve roots (middle radicular group)

Involvement of C8/T1nerve roots (lower radicular group)

d. Indicate severity of radiculopathy and side affected:

Right:  Not affected  Mild  Moderate  Severe

Left:  Not affected  Mild  Moderate  Severe

**12. Other neurologic abnormalities**

Does the Veteran have any other neurologic abnormalities related to a cervical spine (neck) condition (such

as bowel or bladder problems due to cervical myelopathy)?

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Also complete appropriate Questionnaire, if indicated.

**13. Intervertebral disc syndrome (IVDS) and incapacitating episodes**

a. Does the Veteran have IVDS of the cervical spine?

Yes  No

b. If yes, has the Veteran had any incapacitating episodes over the past 12 months due to IVDS?

Yes  No

NOTE: For VA purposes, an incapacitating episode is a period of acute symptoms severe enough to require

prescribed bed rest and treatment by a physician.

If yes, provide the total duration over the past 12 months:

Less than 1 week

At least 1 week but less than 2 weeks

At least 2 weeks but less than 4 weeks

At least 4 weeks but less than 6 weeks

At least 6 weeks

**14. Assistive devices**

a. 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

b. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for

each condition: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**15. Remaining effective function of the extremities**

Due to a cervical spine (neck) 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.; functions of 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

**16. Other pertinent physical findings, complications, conditions, signs and/or symptoms**

1. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any

conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39

square cm (6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

1. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or

symptoms?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**17. Diagnostic testing**

The diagnosis of arthritis must be confirmed by imaging studies. Once 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.

For purposes of this examination, the diagnosis of IVDS and/or radiculopathy can be made by a history of

characteristic radiating pain and/or sensory changes in the arms, and objective clinical findings, which may

include the asymmetrical loss or decrease of reflexes, decreased strength and/or abnormal sensation.

a. Have imaging studies of the cervical spine been performed and are the results available?

Yes  No

If yes, is arthritis (degenerative joint disease) documented?

Yes  No

b. Does the Veteran have a vertebral fracture?

Yes  No

If yes, provide percent of loss of vertebral body: \_\_\_\_\_\_\_\_\_\_\_\_

c. Are there any other significant diagnostic test findings and/or results?

Yes  No

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

**18. Functional impact**

Does the Veteran’s cervical spine (neck) condition impact on his or her ability to work?

Yes  No

If yes, describe the impact of each of the Veteran’s cervical spine (neck) conditions, providing one or more examples\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**19. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to complete VA’s review of the Veteran’s application.

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## 6.4. DBQ Peripheral Nerves Conditions (Not Including Diabetic Sensory-Motor Peripheral Neuropathy)

Name of patient/Veteran: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_SSN:

**Your patient is applying to the U. S. Department of Veterans Affairs (VA) for disability benefits.  VA**

**will consider the information you provide on this questionnaire as part of their evaluation in**

**processing the Veteran’s claim.**

**1. Diagnosis**

Does the Veteran have a peripheral nerve condition or peripheral neuropathy?

Yes  No

If yes, provide only diagnoses that pertain to a peripheral nerve condition and/or peripheral neuropathy:

Diagnosis #1: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #2: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Diagnosis #3: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

ICD code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of diagnosis: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If there are additional diagnoses that pertain to a peripheral nerve condition and/or peripheral neuropathy, list using

above format: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

DEFINITIONS: For VA purposes, neuralgia indicates a condition characterized by a dull and intermittent pain of

typical distribution so as to identify the nerve, while neuritis is characterized by loss of reflexes, muscle atrophy

sensory disturbances and constant pain, at times excruciating.

**2. Medical history**

a. Describe the history (including onset and course) of the Veteran’s peripheral nerve condition (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Dominant hand

Right  Left  Ambidextrous

**3. Symptoms**

a. Does the Veteran have any symptoms attributable to any peripheral nerve conditions?

Yes  No

Constant pain (may be excruciating at times)

Right upper extremity:  None  Mild  Moderate  Severe

Left upper extremity:  None  Mild  Moderate  Severe

Right lower extremity:  None  Mild  Moderate  Severe

Left lower extremity:  None  Mild  Moderate  Severe

Intermittent pain (usually dull)

Right upper extremity:  None  Mild  Moderate  Severe

Left upper extremity:  None  Mild  Moderate  Severe

Right lower extremity:  None  Mild  Moderate  Severe

Left lower extremity:  None  Mild  Moderate  Severe

Paresthesias and/or dysesthesias

Right upper extremity:  None  Mild  Moderate  Severe

Left upper extremity:  None  Mild  Moderate  Severe

Right lower extremity:  None  Mild  Moderate  Severe

Left lower extremity:  None  Mild  Moderate  Severe

Numbness

Right upper extremity:  None  Mild  Moderate  Severe

Left upper extremity:  None  Mild  Moderate  Severe

Right lower extremity:  None  Mild  Moderate  Severe

Left lower extremity:  None  Mild  Moderate  Severe

b.  Other symptoms (describe symptoms, location and severity: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**4. Muscle strength testing**

a. 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

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

b. Does the Veteran have muscle atrophy?

Yes  No

If muscle atrophy is present, indicate location: \_\_\_\_\_\_\_\_\_

For each instance of muscle atrophy, provide measurements in centimeters of normal side and atrophied side,

measured at maximum muscle bulk:

Normal side: \_\_\_\_\_ cm. Atrophied side: \_\_\_\_\_ cm.

**5. Reflex exam**

Rate deep tendon reflexes (DTRs) according to the following scale:

0 Absent

1+ Hypoactive

2+ Normal

3+ Hyperactive without clonus

4+ Hyperactive 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+

**6. Sensory exam**

Indicate results for sensation testing for light touch:

All normal

Shoulder area (C5): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Inner/outer forearm (C6/T1): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Hand/fingers (C6-8): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Upper anterior thigh (L2): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Thigh/knee (L3/4): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Lower leg/ankle (L4/L5/S1): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Foot/toes (L5): Right:  Normal  Decreased  Absent

Left:  Normal  Decreased  Absent

Other sensory findings, if any: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**7. Trophic changes**

Does the Veteran have trophic changes (characterized by loss of extremity hair, smooth, shiny skin, etc.)

attributable to peripheral neuropathy?

Yes  No

If yes, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**8. Gait**

Is the Veteran’s gait normal?

Yes  No

If no, describe abnormal gait: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Provide etiology of abnormal gait: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**9. Special tests for median nerve**

Were special tests indicated and performed for median nerve evaluation?

Yes  No

If yes, indicate results:

Phalen’s sign: Right:  Positive  Negative

Left:  Positive  Negative

Tinel’s sign: Right:  Positive  Negative

Left:  Positive  Negative

**10. Nerves Affected: Severity evaluation for upper extremity nerves and radicular groups**

Based on symptoms and findings from this exam, complete the following section to provide an estimation of

the severity of the Veteran’s peripheral neuropathy. This summary provides useful information for VA purposes.

NOTE: For VA purposes, the term “incomplete paralysis" indicates a degree of lost or impaired function

substantially less than the description of complete paralysis that is given with each nerve.

If the nerve is completely paralyzed, check the box for “complete paralysis.” If the nerve is not completely

paralyzed, check the box for “incomplete paralysis” and indicate severity. For VA purposes, when nerve

impairment is wholly sensory, the evaluation should be mild, or at most, moderate.

Indicate affected nerves, side affected and severity of condition:

a. Radial nerve (musculospiral nerve)

Note: Complete paralysis (hand and fingers drop, wrist and fingers flexed; cannot extend hand at wrist,

extend proximal phalanges of fingers, extend thumb or make lateral movement of wrist; supination of hand,

elbow extension and flexion weak, hand grip impaired)

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

b. Median nerve

Note: Complete paralysis (hand inclined to the ulnar side, index and middle fingers extended, atrophy

of thenar eminence, cannot make fist, defective opposition of thumb, cannot flex distal phalanx of thumb; wrist

flexion weak)

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

c. Ulnar nerve

Note: Complete paralysis ("griffin claw" deformity, atrophy in dorsal interspaces, thenar and hypothenar

eminences; cannot extend ring and little finger, cannot spread fingers, cannot adduct the thumb; wrist

flexion weakened)

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

d. Musculocutaneous nerve

Note: Complete paralysis (weakened flexion of elbow and supination of forearm)

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

e. Circumflex nerve

Note: Complete paralysis (innervates deltoid and teres minor; cannot abduct arm, outward rotation is

weakened).

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

f. Long thoracic nerve

Note: Complete paralysis (inability to raise arm above shoulder level, winged scapula deformity).

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

g. Upper radicular group (5th & 6th cervicals)

Note: Complete paralysis (all shoulder and elbow movements lost; hand and wrist movements not affected)

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

h. Middle radicular group

Note: Complete paralysis (adduction, abduction, rotation of arm, flexion of elbow and extension of wrist lost).

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

i. Lower radicular group

Note: Complete paralysis (instrinsic hand muscles, wrist and finger flexors paralyzed; substantial loss of

use of hand).

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

**11. Nerves Affected: Severity evaluation for lower extremity nerves**

Based on symptoms and findings from this exam, complete the following section to provide an estimation of the

severity of the Veteran’s peripheral neuropathy. This summary provides useful information for VA purposes.

NOTE: For VA purposes, the term “incomplete paralysis" indicates a degree of lost or impaired function

substantially less than the description of complete paralysis that is given with each nerve.

If the nerve is completely paralyzed, check the box for “complete paralysis.” If the nerve is not completely

paralyzed, check the box for “incomplete paralysis” and indicate severity. For VA purposes, when nerve

impairment is wholly sensory, the evaluation should be mild, or at most, moderate.

Indicate affected nerves, side affected and severity of condition:

a. Sciatic nerve

Note: Complete paralysis (foot dangles and drops, no active movement of muscles below the knee, flexion of knee weakened or lost).

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Moderately Severe  Severe, with marked muscular atrophy

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Moderately Severe  Severe, with marked muscular atrophy

b. External popliteal (common peroneal) nerve

Note: Complete paralysis (food drop, cannot dorsiflex foot or extend toes; dorsum of foot and toes are numb).

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

c. Musculocutaneous (superficial peroneal) nerve

Note: Complete paralysis (eversion of foot weakened).

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

d. Anterior tibial (deep peroneal) nerve

Note: Complete paralysis (dorsiflexion of foot lost).

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysisI

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

e. Internal popliteal (tibial) nerve

Note: Complete paralysis (plantar flexion lost, frank adduction of foot impossible, flexion and separation of

toes abolished; no muscle in sole can move; in lesions of the nerve high in popliteal fossa, plantar flexion

of foot is lost)

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

f. Posterior tibial nerve

Note: Complete paralysis (paralysis of all muscles of sole of foot, frequently with painful paralysis of a

causalgic nature; loss of toe flexion; adduction weakened; plantar flexion impaired)

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

g. Anterior crural (femoral) nerve

Note: Complete paralysis (paralysis of quadriceps extensor muscles).

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

h. Internal saphenous nerve

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

i. Obturator nerve

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

j. External cutaneous nerve of the thigh

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

k. Illio-inguinal nerve

Right:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

Left:

Normal  Incomplete paralysis  Complete paralysis

If incomplete paralysis is checked, indicate severity:

Mild  Moderate  Severe

**12. Assistive devices**

a. 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 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

1. If the Veteran uses any assistive devices, specify the condition and identify the assistive device used for each

condition: \_\_\_\_\_\_\_\_\_\_

**13. Remaining effective function of the extremities**

Due to peripheral nerve conditions, 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 (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): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**14. Other pertinent physical findings, complications, conditions, signs and/or symptoms**

1. Does the Veteran have any scars (surgical or otherwise) related to any conditions or to the treatment of any

conditions listed in the Diagnosis section above?

Yes  No

If yes, are any of the scars painful and/or unstable, or is the total area of all related scars greater than 39 square cm

(6 square inches)?

Yes  No

If yes, also complete a Scars Questionnaire.

b. Does the Veteran have any other pertinent physical findings, complications, conditions, signs or symptoms?

Yes  No

If yes, describe (brief summary): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**15. Diagnostic testing**

For the purpose of this examination, electromyography (EMG) studies are usually rarely required to diagnose

specific peripheral nerve conditions in the appropriate clinical setting. If EMG studies are in the medical record and

reflect the Veteran’s current condition, repeat studies are not indicated.

a. Have EMG studies been performed?

Yes  No

Extremities tested:

Right upper extremity Results:  Normal  Abnormal Date: \_\_\_\_\_\_\_\_\_\_

Left upper extremity Results:  Normal  Abnormal Date: \_\_\_\_\_\_\_\_\_\_

Right lower extremity Results:  Normal  Abnormal Date: \_\_\_\_\_\_\_\_\_\_

Left lower extremity Results:  Normal  Abnormal Date: \_\_\_\_\_\_\_\_\_\_

If abnormal, describe: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

b. Are there any other significant diagnostic test findings and/or results?

Yes  No

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

**16. Functional**

Does the Veteran’s peripheral nerve condition and/or peripheral neuropathy impact his or her ability to work?

Yes  No

If yes, describe impact of each of the Veteran’s peripheral nerve and/or peripheral neuropathy condition(s),

providing one or more examples: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**17. Remarks, if any:** ­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Physician signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_

Physician printed name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical license #: \_\_\_\_\_\_\_\_\_\_\_\_\_ Physician address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**NOTE**: VA may request additional medical information, including additional examinations if necessary to complete

VA’s review of the Veteran’s application.

7. Software and Documentation Retrieval

## 7.1 Software

The VistA software is being distributed as a PackMan patch message through the National Patch

Module (NPM). The KIDS build for this patch is DVBA\*2.7\*167.

## 7.2 User Documentation

The user documentation for this patch may be retrieved directly using FTP. The preferred method

is to FTP the files from:

**REDACTED**

This transmits the files from the first available FTP server. Sites may also elect to retrieve software

directly from a specific server as follows:

|  |  |  |
| --- | --- | --- |
| **OI&T Field Office** | **FTP Address** | **Directory** |
| **Albany** | REDACTED | [anonymous.software] |
| **Hines** | REDACTED | [anonymous.software] |
| **Salt Lake City** | REDACTED | [anonymous.software] |

|  |  |  |
| --- | --- | --- |
| **File Name** | **Format** | **Description** |
| **DVBA\_27\_P167\_RN.PDF** | Binary | Release Notes |

## 7.3 Related Documents

The VistA Documentation Library (VDL) web site will also contain the DVBA\*2.7\*167 Release Notes. This web

site is usually updated within 1-3 days of the patch release date.

The VDL web address for CAPRI documentation is: <http://www.va.gov/vdl/application.asp?appid=133>.

Content and/or changes to the DBQs are communicated by the Disability Examination Management Office (DEMO) through:  <http://vbacodmoint1.vba.va.gov/bl/21/DBQ/default.asp>