



**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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1. 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).

2. 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)**

3. Associated Remedy Tickets & New Service Requests

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

4. Defects Fixes

There are no CAPRI DBQ Templates or AMIE – DBQ Worksheet defects fixes associated with patch DVBA*2.7*167.

5. Enhancements

This section provides an overview of the modifications and primary functionality that will be delivered in Patch DVBA*2.7*167.

5.1 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)**

5.2 CAPRI – DBQ Template Modifications

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

5.3 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.

5.4 AMIE–DBQ Worksheet Modifications

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

6. 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:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Elbow extension:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Wrist flexion:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Wrist extension:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Grip:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Pinch (thumb to index finger):	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Knee extension:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Ankle plantar flexion:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Ankle dorsiflexion:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 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:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Triceps:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Brachioradialis:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Knee:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Ankle:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+

e. Plantar (Babinski) reflex

Right:	<input type="checkbox"/> plantar flexion (normal, or negative Babinski)
	<input type="checkbox"/> dorsiflexion (abnormal, or positive Babinski)
Left:	<input type="checkbox"/> plantar flexion (normal, or negative Babinski)
	<input type="checkbox"/> 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 require a 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:

Measure ROM 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 where post-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:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Knee extension:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Ankle plantar flexion:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Ankle dorsiflexion:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Great toe extension:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 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:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Ankle:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+

10. Sensory exam

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

All normal

Upper anterior thigh (L2):	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Thigh/knee (L3/4):	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Lower leg/ankle (L4/L5/S1):	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Foot/toes (L5):	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> 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/L3/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

Measure ROM 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:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Elbow extension	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Wrist flexion:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Wrist extension:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Finger Flexion:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Finger Abduction	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 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:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Triceps:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Brachioradialis:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+

10. Sensory exam

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

All normal

Shoulder area (C5):	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent

Inner/outer forearm (C6/T1):	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> 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/T1 nerve 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

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): _____

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.

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:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Right lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

Paresthesias and/or dysesthesias

Right upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Right lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe

Numbness

Right upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left upper extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Right lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> Severe
Left lower extremity:	<input type="checkbox"/> None	<input type="checkbox"/> Mild	<input type="checkbox"/> Moderate	<input type="checkbox"/> 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:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Elbow extension:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Wrist flexion:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Wrist extension:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Grip:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Pinch (thumb to index finger):	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Knee extension:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Ankle plantar flexion:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
Ankle dorsiflexion:	Right:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 0/5
	Left:	<input type="checkbox"/> 5/5	<input type="checkbox"/> 4/5	<input type="checkbox"/> 3/5	<input type="checkbox"/> 2/5	<input type="checkbox"/> 1/5	<input type="checkbox"/> 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:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Triceps:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Brachioradialis:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Knee:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
Ankle:	Right:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+
	Left:	<input type="checkbox"/> 0	<input type="checkbox"/> 1+	<input type="checkbox"/> 2+	<input type="checkbox"/> 3+	<input type="checkbox"/> 4+

6. Sensory exam

Indicate results for sensation testing for light touch:

All normal

Shoulder area (C5):	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Inner/outer forearm (C6/T1):	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Hand/fingers (C6-8):	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Upper anterior thigh (L2):	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Thigh/knee (L3/4):	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Lower leg/ankle (L4/L5/S1):	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
Foot/toes (L5):	Right:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> Absent
	Left:	<input type="checkbox"/> Normal	<input type="checkbox"/> Decreased	<input type="checkbox"/> 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 (intrinsic 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 (foot 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 paralysis

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. Ilio-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):

- | | | | | |
|-------------------------------------|-------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <input type="checkbox"/> Wheelchair | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Brace(s) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Crutch(es) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Cane(s) | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |

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:

download.vista.med.va.gov

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	ftp.fo-albany.med.va.gov	[anonymous.software]
Hines	ftp.fo-hines.med.va.gov	[anonymous.software]
Salt Lake City	ftp.fo-slc.med.va.gov	[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>