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:	☐ 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 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 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

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:	☐ 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

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.

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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

c. 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

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): _____

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