

**IMPORTANT** - THE DEPARTMENT OF VETERANS AFFAIRS (VA) **WILL NOT PAY OR REIMBURSE** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION ON REVERSE BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER

**NOTE TO PHYSICIAN** - 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.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA 21-2507, C&P EXAMINATION REQUEST?

YES  NO

How was the examination completed (check all that apply)?

- In-person examination
- Records reviewed
- Examination via approved video telehealth
- Other, please specify in comments box:

Comments:

**ACCEPTABLE CLINICAL EVIDENCE (ACE)**

INDICATE METHOD USED TO OBTAIN MEDICAL INFORMATION TO COMPLETE THIS DOCUMENT:

- Review of available records (without in-person or video telehealth examination) using the Acceptable Clinical Evidence (ACE) process because the existing medical evidence provided sufficient information on which to prepare the questionnaire and such an examination will likely provide no additional relevant evidence.
- Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

**EVIDENCE REVIEW**

EVIDENCE REVIEWED (check all that apply):

- Not requested
- VA claims file (hard copy paper C-file)
- VA e-folder (VBMS or Virtual VA)
- CPRS
- Other (please identify other evidence reviewed):
- No records were reviewed

EVIDENCE COMMENTS:

**SECTION I - DIAGNOSIS**

**NOTE:** These are condition(s) for which an evaluation has been requested on an exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. LIST THE CLAIMED CONDITION(S) THAT PERTAIN TO THIS DBQ:

**NOTE:** These are the diagnoses determined during this current evaluation of the claimed condition(s) listed above. If there is no diagnosis, if the diagnosis is different from a previous diagnosis for this condition, or if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in comments section. Date of diagnosis can be the date of the evaluation if the clinician is making the initial diagnosis, or an approximate date determined through record review or reported history.

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

The Veteran does not have a current diagnosis associated with any claimed condition listed above. (Explain your findings and reasons in comments section.)

	Side affected:	ICD Code:	Date of diagnosis:
<input type="checkbox"/> Lateral collateral ligament sprain (chronic/recurrent)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Deltoid ligament sprain (chronic/recurrent)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Osteochondritis dissecans to include osteochondral fracture	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Impingement (anterior/posterior (or trigonum syndrome)/anterolateral))	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Tendonitis (achilles/peroneal/posterior tibial)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Retrocalcaneal bursitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Achilles' tendon rupture	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Osteoarthritis of the ankle	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Avascular necrosis, talus	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Ankle joint replacement	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Ankylosis of ankle, subtalar or tarsal joint	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritic conditions	Side affected:	ICD Code:	Date of diagnosis:
<input type="checkbox"/> Arthritis, degenerative	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, gonorrhoeal	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, pneumococcic	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, streptococcic	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, syphilitic	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, rheumatoid	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, traumatic	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, typhoid	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Arthritis, other types (specify)	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Inflammatory conditions	Side affected:	ICD Code:	Date of diagnosis:
<input type="checkbox"/> Osteoporosis, with joint manifestations	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Osteomalacia	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Bones, new growths of, benign	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Osteitis deformans	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Gout	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Hydrarthrosis, intermittent	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Bursitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Synovitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Myositis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Periostitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Myositis ossificans	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____
<input type="checkbox"/> Tenosynovitis	<input type="checkbox"/> Right <input type="checkbox"/> Left <input type="checkbox"/> Both	_____	Right: _____ Left: _____

Other (*specify*)  
 Other diagnosis #1: \_\_\_\_\_  
 Side affected:  Right  Left  Both ICD Code: \_\_\_\_\_ Date of diagnosis: Right: \_\_\_\_\_ Left: \_\_\_\_\_  
 Other diagnosis #2: \_\_\_\_\_  
 Side affected:  Right  Left  Both ICD Code: \_\_\_\_\_ Date of diagnosis: Right: \_\_\_\_\_ Left: \_\_\_\_\_  
 Other diagnosis #3: \_\_\_\_\_  
 Side affected:  Right  Left  Both ICD Code: \_\_\_\_\_ Date of diagnosis: Right: \_\_\_\_\_ Left: \_\_\_\_\_  
 If there are additional diagnoses that pertain to ankle conditions, list using above format:

1C. COMMENTS (*if any*):

1D. WAS AN OPINION REQUESTED ABOUT THIS CONDITION (*internal VA only*)?

Yes  No  N/A

**SECTION II - MEDICAL HISTORY**

2A. DESCRIBE THE HISTORY (*including onset and course*) OF THE VETERAN'S ANKLE CONDITION (*brief summary*):

2B. DOES THE VETERAN REPORT FLARE-UPS OF THE ANKLE?

Yes  No

IF YES, DOCUMENT THE VETERAN'S DESCRIPTION OF THE IMPACT OF FLARE-UPS IN HIS OR HER OWN WORDS:

2C. DOES THE VETERAN REPORT HAVING ANY FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT OF THE JOINT OR EXTREMITY BEING EVALUATED ON THIS DBQ (*regardless of repetitive use*)?

Yes  No

IF YES, DOCUMENT THE VETERAN'S DESCRIPTION OF FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT IN HIS OR HER OWN WORDS:

**SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATIONS**

There are several separate parameters requested for describing function of a joint. The question of "Does this ROM contribute to a functional loss" asks if there is a functional loss that can be ascribed to any documented loss of range of motion and unlike later questions, does not take into account the numerous other factors to be considered.

Subsequent questions take into account additional factors such as pain, fatigue, weakness, lack of endurance or incoordination. If there is pain noted on examination, it is important to understand whether or not that pain itself contributes to functional loss. Ideally a claimant would be seen immediately after that repetitive use over time or during a flare up, however, this is not always feasible.

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

Optimally, description of any additional loss of function should be provided as what the degrees range of motion would be opined to look like in these given scenarios. However, when this is not feasible, a clear as possible description of that loss should be provided. This same information (minus the three repetitions) is asked to be provided with regards to flare ups.

**3A. INITIAL ROM MEASUREMENTS**

RIGHT ANKLE	<input type="checkbox"/> All Normal	<input type="checkbox"/> Unable to test	If "Unable to test" or "Not indicated", please explain:
	<input type="checkbox"/> Abnormal or outside of normal range	<input type="checkbox"/> Not indicated	

Dorsiflexion (0-20 degrees): \_\_\_\_\_ to \_\_\_\_\_ degrees      Plantar Flexion (0-45 degrees): \_\_\_\_\_ to \_\_\_\_\_ degrees

If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than an ankle condition, such as age, body habitus, neurologic disease), please describe:	If abnormal, does the range of motion itself contribute to a functional loss? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
---	--

Description of Pain <i>(select the best response):</i> <input type="checkbox"/> No pain noted on exam <input type="checkbox"/> Pain noted on exam on rest / non-movement <input type="checkbox"/> Pain noted on exam but does not result in / cause functional loss <input type="checkbox"/> Pain noted on examination and causes functional loss	If noted on examination, which ROM exhibited pain <i>(select all that apply):</i> <input type="checkbox"/> Dorsiflexion <input type="checkbox"/> Plantar Flexion	Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain. Include location, severity, and relationship to condition(s).
	Is there evidence of pain with weight bearing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there objective evidence of crepitus? <input type="checkbox"/> Yes <input type="checkbox"/> No

LEFT ANKLE	<input type="checkbox"/> All Normal	<input type="checkbox"/> Unable to test	If "Unable to test" or "Not indicated", please explain:
	<input type="checkbox"/> Abnormal or outside of normal range	<input type="checkbox"/> Not indicated	

Dorsiflexion (0-20 degrees): \_\_\_\_\_ to \_\_\_\_\_ degrees      Plantar Flexion (0-45 degrees): \_\_\_\_\_ to \_\_\_\_\_ degrees

If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than an ankle condition, such as age, body habitus, neurologic disease), please describe:	If abnormal, does the range of motion itself contribute to a functional loss? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain:
---	--

Description of Pain <i>(select the best response):</i> <input type="checkbox"/> No pain noted on exam <input type="checkbox"/> Pain noted on exam on rest / non-movement <input type="checkbox"/> Pain noted on exam but does not result in / cause functional loss <input type="checkbox"/> Pain noted on examination and causes functional loss	If noted on examination, which ROM exhibited pain <i>(select all that apply):</i> <input type="checkbox"/> Dorsiflexion <input type="checkbox"/> Plantar Flexion	Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? <input type="checkbox"/> Yes <input type="checkbox"/> No If yes, please explain. Include location, severity, and relationship to condition(s).
	Is there evidence of pain with weight bearing? <input type="checkbox"/> Yes <input type="checkbox"/> No	Is there objective evidence of crepitus? <input type="checkbox"/> Yes <input type="checkbox"/> No

**SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATIONS**

**3B. OBSERVED REPETITIVE USE**

Ankle	Is the veteran able to perform repetitive-use testing with at least three repetitions?	Is there additional loss of function or range of motion after three repetitions?	Joint Movement	ROM after 3 repetitions:
RIGHT ANKLE	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, perform repetitive-use testing If no, provide reason:	<input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, report ROM after a minimum of 3 repetitions.  If no, documentation of ROM after repetitive-use testing is not required.	Plantar Flexion (0-45)	_____ to _____
			Dorsiflexion (0-20)	_____ to _____
Select all factors that cause this functional loss: <input type="checkbox"/> N/A <input type="checkbox"/> Pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination				
Ankle	Is the veteran able to perform repetitive-use testing with at least three repetitions?	Is there additional loss of function or range of motion after three repetitions?	Joint Movement	ROM after 3 repetitions:
LEFT ANKLE	<input type="checkbox"/> Yes <input type="checkbox"/> No If yes, perform repetitive-use testing If no, provide reason:	<input type="checkbox"/> Yes <input type="checkbox"/> No  If yes, report ROM after a minimum of 3 repetitions.  If no, documentation of ROM after repetitive-use testing is not required.	Plantar Flexion (0-45)	_____ to _____
			Dorsiflexion (0-20)	_____ to _____
Select all factors that cause this functional loss: <input type="checkbox"/> N/A <input type="checkbox"/> Pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination				

**3C. REPEATED USE OVER TIME**

Ankle	Is the Veteran being examined immediately after repetitive use over time?	If the examination is <b>not</b> being conducted immediately after repetitive use over time:	If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:		
RIGHT ANKLE	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> The examination is medically consistent with the Veteran's statements describing functional loss with repetitive use over time. <input type="checkbox"/> The examination is medically inconsistent with the Veteran's statements describing functional loss with repetitive use over time. Please explain. <input type="checkbox"/> The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss with repetitive use over time.			
				Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to say without mere speculation	If unable to say without mere speculation, please explain:
				Select all factors that cause this functional loss: <input type="checkbox"/> N/A <input type="checkbox"/> Pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination	
				Are you able to describe in terms of Range of Motion? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, please describe:
				Dorsiflexion (0-20 degrees): _____ to _____ degrees Plantar Flexion (0-45 degrees): _____ to _____ degrees	
Ankle	Is the Veteran being examined immediately after repetitive use over time?	If the examination is <b>not</b> being conducted immediately after repetitive use over time:	If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:		
LEFT ANKLE	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> The examination is medically consistent with the Veteran's statements describing functional loss with repetitive use over time. <input type="checkbox"/> The examination is medically inconsistent with the Veteran's statements describing functional loss with repetitive use over time. Please explain. <input type="checkbox"/> The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss with repetitive use over time.			

**SECTION V - REPEATED USE OVER TIME (Continued)**

**3C. REPEATED USE OVER TIME (Continued)**

<b>LEFT ANKLE (Continued)</b>	Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to say without mere speculation	If unable to say without mere speculation, please explain:
	Select all factors that cause this functional loss: <input type="checkbox"/> N/A <input type="checkbox"/> Pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination	
	Are you able to describe in terms of Range of Motion? <input type="checkbox"/> Yes <input type="checkbox"/> No	If no, please describe:
	Dorsiflexion (0-20 degrees): _____ to _____ degrees Plantar Flexion (0-45 degrees): _____ to _____ degrees	

**3D. FLARE UPS**

Ankle	Is the examination being conducted during a flare up?	If the examination is <b>not</b> being conducted during a flare up:	If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:
<b>RIGHT ANKLE</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> The examination is medically consistent with the Veteran's statements describing functional loss during flare up. <input type="checkbox"/> The examination is medically inconsistent with the Veteran's statements describing functional loss during flare up. <input type="checkbox"/> The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss during flare up.	
	Does pain, weakness, fatigability or incoordination significantly limit functional ability with flare ups?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to say without mere speculation		If unable to say without mere speculation, please explain:
	Select all factors that cause this functional loss: <input type="checkbox"/> N/A <input type="checkbox"/> Pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination		
	Are you able to describe in terms of Range of Motion? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, please describe:
	Dorsiflexion (0-20 degrees): _____ to _____ degrees Plantar Flexion (0-45 degrees): _____ to _____ degrees		
<b>LEFT ANKLE</b>	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> The examination is medically consistent with the Veteran's statements describing functional loss during flare up. <input type="checkbox"/> The examination is medically inconsistent with the Veteran's statements describing functional loss during flare up. <input type="checkbox"/> The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss during flare up.	
	Does pain, weakness, fatigability or incoordination significantly limit functional ability with flare ups?  <input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unable to say without mere speculation		If unable to say without mere speculation, please explain:
	Select all factors that cause this functional loss: <input type="checkbox"/> N/A <input type="checkbox"/> Pain <input type="checkbox"/> Fatigue <input type="checkbox"/> Weakness <input type="checkbox"/> Lack of endurance <input type="checkbox"/> Incoordination		
	Are you able to describe in terms of Range of Motion? <input type="checkbox"/> Yes <input type="checkbox"/> No		If no, please describe:
	Dorsiflexion (0-20 degrees): _____ to _____ degrees Plantar Flexion (0-45 degrees): _____ to _____ degrees		

3E. ADDITIONAL FACTORS CONTRIBUTING TO DISABILITY

RIGHT ANKLE

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

- None
- Less movement than normal (*due to ankylosis, adhesions, etc.*)
- More movement than normal (*from flail joints, fracture nonunions, etc.*)
- Weakened movement (*due to muscle or peripheral nerve injury etc.*)
- Other, please describe:
- Swelling
- Deformity
- Atrophy of disuse
- Instability of station
- Disturbance of locomotion
- Interference with sitting
- Interference with standing

LEFT ANKLE

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

- None
- Less movement than normal (*due to ankylosis, adhesions, etc.*)
- More movement than normal (*from flail joints, fracture nonunions, etc.*)
- Weakened movement (*due to muscle or peripheral nerve injury etc.*)
- Other, please describe:
- Swelling
- Deformity
- Atrophy of disuse
- Instability of station
- Disturbance of locomotion
- Interference with sitting
- Interference with standing

SECTION IV - MUSCLE STRENGTH TESTING

4A. MUSCLE STRENGTH - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

- 0/5 No muscle movement  
 1/5 Palpable or visible muscle contraction, but no joint movement  
 2/5 Active movement with gravity eliminated  
 3/5 Active movement against gravity  
 4/5 Active movement against some resistance  
 5/5 Normal strength

Ankle	Flexion	Rate Strength	Is there a reduction in muscle strength?	If yes, is the reduction entirely due to the claimed condition in the Diagnosis section?	If no (the reduction is not entirely due to the claimed condition), provide rationale:
RIGHT ANKLE	Plantar Flexion	/5	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Dorsiflexion	/5			
LEFT ANKLE	Plantar Flexion	/5	<input type="checkbox"/> Yes <input type="checkbox"/> No	<input type="checkbox"/> Yes <input type="checkbox"/> No	
	Dorsiflexion	/5			

4B. DOES THE VETERAN HAVE MUSCLE ATROPHY?

- YES  NO
- IF YES, IS THE MUSCLE ATROPHY DUE TO THE CLAIMED CONDITION IN THE DIAGNOSIS SECTION?
- YES  NO IF NO, PROVIDE RATIONALE:

FOR ANY MUSCLE ATROPHY DUE TO A DIAGNOSES LISTED IN SECTION 1, INDICATE SIDE AND SPECIFIC LOCATION OF ATROPHY, PROVIDING MEASUREMENTS IN CENTIMETERS OF NORMAL SIDE AND CORRESPONDING ATROPHIED SIDE, MEASURED AT MAXIMUM MUSCLE BULK.

LOCATION OF MUSCLE ATROPHY:

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

CIRCUMFERENCE OF MORE NORMAL SIDE: \_\_\_\_\_ cm

CIRCUMFERENCE OF ATROPHIED SIDE: \_\_\_\_\_ cm

**SECTION IV - MUSCLE STRENGTH TESTING (Continued)**

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

CIRCUMFERENCE OF MORE NORMAL SIDE: \_\_\_\_\_ cm

CIRCUMFERENCE OF ATROPHIED SIDE: \_\_\_\_\_ cm

4C. COMMENTS, IF ANY:

**SECTION V - ANKYLOSIS**

COMPLETE THIS SECTION IF VETERAN HAS ANKYLOSIS OF THE ANKLE.

**NOTE:** Ankylosis is the immobilization and consolidation of a joint due to disease, injury or surgical procedure.

5A. INDICATE SEVERITY OF ANKYLOSIS AND SIDE AFFECTED (check all that apply):

RIGHT SIDE:

LEFT SIDE:

No ankylosis

No ankylosis

In plantar flexion

In plantar flexion

If checked, provide degrees: \_\_\_\_\_

If checked, provide degrees: \_\_\_\_\_

In dorsiflexion

In dorsiflexion

If checked, provide degrees: \_\_\_\_\_

If checked, provide degrees: \_\_\_\_\_

With an abduction deformity

With an abduction deformity

With an inversion deformity

With an inversion deformity

With an eversion deformity

With an eversion deformity

In good weight-bearing position

In good weight-bearing position

In poor weight-bearing position

In poor weight-bearing position

5B. COMMENTS, IF ANY:



**SECTION VI - JOINT STABILITY**

Ankle	Is ankle instability or dislocation suspected?	If yes, complete the following:	
		Anterior Drawer Test Is there laxity compared with opposite side?	Talar Tilt Test Is there laxity compared with opposite side?
RIGHT ANKLE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNABLE TO TEST	<input type="checkbox"/> YES <input type="checkbox"/> NO
LEFT ANKLE	<input type="checkbox"/> YES <input type="checkbox"/> NO	<input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> UNABLE TO TEST	<input type="checkbox"/> YES <input type="checkbox"/> NO

**SECTION VII - ADDITIONAL COMMENTS**

7. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER HAD "SHIN SPLINTS", STRESS FRACTURES, ACHILLES TENDONITIS, ACHILLES TENDON RUPTURE, MALUNION OF CALCANEUS (*os calcis*) OR TALUS (*astragalus*), OR HAS THE VETERAN HAD A TALECTOMY (*astragalectomy*)?

YES  NO

IF YES, INDICATE CONDITION AND COMPLETE THE APPROPRIATE SECTIONS BELOW:

SHIN SPLINTS (*medial tibial stress syndrome*)

INDICATE SIDE AFFECTED:  RIGHT  LEFT  BOTH

DOES THIS CONDITION AFFECT ROM OF ANKLE?

YES (*If "yes," complete ROM section of ankle on this DBQ*)

NO

DOES THIS CONDITION AFFECT ROM OF KNEE?

YES (*If "yes," complete VA Form 21-0960M-9 Knee and Lower Leg Conditions*)

NO

DESCRIBE CURRENT SYMPTOMS:

STRESS FRACTURE OF THE LOWER LEG

INDICATE SIDE AFFECTED:  RIGHT  LEFT  BOTH

DESCRIBE CURRENT SYMPTOMS:

ACHILLES TENDONITIS OR ACHILLES TENDON RUPTURE

INDICATE SIDE AFFECTED:  RIGHT  LEFT  BOTH

DESCRIBE CURRENT SYMPTOMS:

MALUNION OF CALCANEUS (*os calcis*) OR TALUS (*astragalus*)

INDICATE SEVERITY AND SIDE AFFECTED:

MODERATE DEFORMITY  RIGHT  LEFT  BOTH

MARKED DEFORMITY  RIGHT  LEFT  BOTH

TALECTOMY

INDICATE SIDE AFFECTED:  RIGHT  LEFT  BOTH

DESCRIBE CURRENT SYMPTOMS:

**SECTION VIII - SURGICAL PROCEDURES**

8. INDICATE ANY SURGICAL PROCEDURES THAT THE VETERAN HAS HAD PERFORMED AND PROVIDE THE ADDITIONAL INFORMATION AS REQUESTED (*check all that apply*):

RIGHT SIDE:

- TOTAL ANKLE JOINT REPLACEMENT  
DATE OF SURGERY: \_\_\_\_\_  
RESIDUALS:  
 None  
 Intermediate degrees of residual weakness, pain or limitation of motion  
 Chronic residuals consisting of severe painful motion or weakness  
 Other, describe: \_\_\_\_\_

LEFT SIDE:

- TOTAL ANKLE JOINT REPLACEMENT  
DATE OF SURGERY: \_\_\_\_\_  
RESIDUALS:  
 None  
 Intermediate degrees of residual weakness, pain or limitation of motion  
 Chronic residuals consisting of severe painful motion or weakness  
 Other, describe: \_\_\_\_\_

- ARTHROSCOPIC OR OTHER ANKLE SURGERY  
TYPE OF SURGERY: \_\_\_\_\_  
DATE OF SURGERY: \_\_\_\_\_

- ARTHROSCOPIC OR OTHER ANKLE SURGERY  
TYPE OF SURGERY: \_\_\_\_\_  
DATE OF SURGERY: \_\_\_\_\_

- RESIDUALS OF ARTHROSCOPIC OR OTHER ANKLE SURGERY  
DESCRIBE RESIDUALS: \_\_\_\_\_

- RESIDUALS OF ARTHROSCOPIC OR OTHER ANKLE SURGERY  
DESCRIBE RESIDUALS: \_\_\_\_\_

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

9A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

- YES  NO

IF YES, DESCRIBE (*brief summary*): \_\_\_\_\_

9B. 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 THESE SCARS PAINFUL OR UNSTABLE; HAVE A TOTAL AREA EQUAL TO OR GREATER THAN 39 SQUARE CM (*6 square inches*); OR ARE LOCATED ON THE HEAD, FACE OR NECK? (An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar.)

- YES  NO

IF YES, ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT.

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

LOCATION: \_\_\_\_\_ MEASUREMENTS: length \_\_\_\_\_ cm X width \_\_\_\_\_ cm.

**NOTE:** If there are multiple scars, enter additional locations and measurements in Comment section below. It is not necessary to also complete a Scars DBQ.

9C. COMMENTS, IF ANY:

**SECTION X - ASSISTIVE DEVICES**

10A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

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

- |                                       |                   |                                     |                                  |                                   |
|---------------------------------------|-------------------|-------------------------------------|----------------------------------|-----------------------------------|
| <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"/> Crutches     | 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 |
| <input type="checkbox"/> Walker       | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |
| <input type="checkbox"/> Other: _____ | Frequency of use: | <input type="checkbox"/> Occasional | <input type="checkbox"/> Regular | <input type="checkbox"/> Constant |

10B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

**SECTION XI - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES**

11. DUE TO THE VETERAN'S ANKLE CONDITIONS, IS THERE FUNCTIONAL IMPAIRMENT OF AN EXTREMITY SUCH THAT NO EFFECTIVE FUNCTIONS REMAINS OTHER THAN THAT WHICH WOULD BE EQUALLY WELL SERVED BY AN AMPUTATION WITH PROSTHESIS? (*Functions of the upper extremity include grasping, manipulation, etc., while functions for the lower extremity include balance and propulsion, etc.*)

- YES, FUNCTIONING IS SO DIMINISHED THAT AMPUTATION WITH PROSTHESIS WOULD EQUALLY SERVE THE VETERAN.  
 NO

IF YES, INDICATE EXTREMITIES FOR WHICH THIS APPLIES:  RIGHT LOWER  LEFT LOWER

FOR EACH CHECKED EXTREMITY, IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, DESCRIBE LOSS OF EFFECTIVE FUNCTION AND PROVIDE SPECIFIC EXAMPLES (*brief summary*):

**NOTE:** The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prosthesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

**SECTION XII - DIAGNOSTIC TESTING**

**NOTE:** Testing listed below is not indicated for every condition. The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, even if in the past, no further imaging studies are required by VA, even if arthritis has worsened.

12A. HAVE IMAGING STUDIES OF THE ANKLE BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

- YES  NO

IF YES, IS DEGENERATIVE OR TRAUMATIC ARTHRITIS DOCUMENTED?

- YES  NO IF YES, INDICATE ANKLE:  RIGHT  LEFT  BOTH

12B. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS OR RESULTS?

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

12C. IF ANY TEST RESULTS ARE OTHER THAN NORMAL, INDICATE RELATIONSHIP OF ABNORMAL FINDINGS TO DIAGNOSED CONDITIONS:

**SECTION XIII - FUNCTIONAL IMPACT**

**NOTE:** Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

13. REGARDLESS OF THE VETERAN'S CURRENT EMPLOYMENT STATUS, DO THE CONDITION(S) LISTED IN THE DIAGNOSIS SECTION IMPACT HIS OR HER ABILITY TO PERFORM ANY TYPE OF OCCUPATIONAL TASK (*such as standing, walking, lifting, sitting, etc.*)?

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

**SECTION XIV - REMARKS**

14. REMARKS, IF ANY:

**SECTION XV - PHYSICIAN'S CERTIFICATION AND SIGNATURE**

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

15A. PHYSICIAN'S SIGNATURE		15B. PHYSICIAN'S PRINTED NAME	15C. DATE SIGNED
15D. PHYSICIAN'S PHONE AND FAX NUMBER	15E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	15F. PHYSICIAN'S ADDRESS	

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

**PRIVACY ACT NOTICE:** VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58/VA21/22/28, Compensation, Pension, Education and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by a Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

**RESPONDENT BURDEN:** We need this information to determine entitlement to benefits (38 U.S.C. 501). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 30 minutes to review the instructions, find the information, and complete the form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at [www.reginfo.gov/public/do/PRAMain](http://www.reginfo.gov/public/do/PRAMain). If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.