Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
BACK (THORACOLUMBAR SPINE) CONDITIONS
DISABILITY BENEFITS QUESTIONNAIRE

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
- ☐ CPRS
- ☐ Other (please identify other evidence reviewed):
- ☐ No records were reviewed

EVIDENCE COMMENTS:

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE/SHE EVER BEEN DIAGNOSED WITH A THORACOLUMBAR SPINE *(back)* CONDITION?

☐ Yes ☐ No

1B. IF YES, PROVIDE ONLY DIAGNOSES THAT PERTAIN TO THORACOLUMBAR SPINE (BACK) CONDITIONS:

FURTHER INSTRUCTIONS: Enter specific diagnosis in diagnosis box(s)with ICD Code and Date of diagnosis

☐ Ankylosing apondylitis	ICD Code: _____	Date of diagnosis: _____	☐ Segmental instability	ICD Code _____	**Date of diagnosis:** _____
☐ Lumbosacral strain	ICD Code: _____	Date of diagnosis: _____	☐ Spinal fusion	ICD Code _____	Date of diagnosis: _____
☐ Degenerative arthritis of the spine	ICD Code: _____	Date of diagnosis: _____	☐ Spinal stenosis	ICD Code _____	Date of diagnosis: _____
☐ Intervertebral disc syndrome	ICD Code: _____	Date of diagnosis: _____	☐ Spondylolisthesis	ICD Code _____	Date of diagnosis: _____
☐ Sacroiliac injury	ICD Code _____	Date of diagnosis: _____	☐ Vertebral dislocation	ICD Code _____	**Date of diagnosis:** _____
☐ Sacroiliac weakness	ICD Code _____	Date of diagnosis: _____	☐ Vertebral fracture	ICD Code _____	Date of diagnosis: _____

1C. IF THERE ARE ADDITIONAL DAIGNOSES PERTAINING TO THORACOLUMBAR SPINE *(back)* CONDITIONS, LIST USING ABOVE FORMAT:

SECTION II - MEDICAL HISTORY

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

2B. DOES THE VETERAN REPORT FLARE-UPS OF THE THORACOLUMBAR SPINE *(back)*?

☐ YES ☐ NO

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

2C. DOES THE VETERAN REPORT HAVING ANY FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT OF THE THORACOLUMBAR SPINE *(back) (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 - INITIAL 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.

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

3A. INITIAL RANGE OF MOTION

☐ All Normal ☐ Unable to test (please explain) If 'Unable to test" or "Not indicated", please explain:

☐ Abnormal or outside of normal range ☐ Not indicated (please explain)

Forward Flexion (0-90):	_____	to	_____ degrees	Left Lateral Flexion (0- 30):	_____	to	_____ degrees
Extension (0-30):	_____	to	_____ degrees	Right Lateral Rotation (0-30):	_____	to	_____ degrees
Right Lateral Flexion (0-30):	_____	to	_____ degrees	Left Lateral Rotation (0-30):	_____	to	_____ degrees

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

If abnormal, does the range of motion itself contribute to a functional loss?

☐ Yes ☐ No

If yes, please explain:

Description of Pain *(select the best response)*:

☐ No pain noted on exam

☐ Pain noted on exam on rest / non-movement

☐ Pain noted on exam but does not result in / cause functional loss

☐ Pain noted on examination and causes functional loss

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

☐ Forward Flexion ☐ Left Lateral Flexion

☐ Extension ☐ Right Lateral Rotation

☐ Right Lateral Flexion ☐ Left Lateral Rotation

Is there evidence of pain with weight bearing?

☐ Yes ☐ No

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

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

3B. OBSERVED REPETITIVE USE

Is the Veteran able to perform repetitive-use testing with at least three repetitions?

☐ Yes

☐ No

If yes, perform repetitive-use testing

If no, please provide reason:

Is there additional loss of function or range of motion after three repetitions?

☐ Yes

☐ No

If yes, report ROM after a minimum of 3 repetitions.

If no, documentation of ROM after repetitive-use testing is not required.

ROM after 3 repetitions:

Forward Flexion (0-90):	_____ to _____
Extension (0-30):	_____ to _____
Right Lateral Flexion (0-30):	_____ to _____
Left Lateral Flexion (0- 30):	_____ to _____
Right Lateral Rotation (0-30):	_____ to _____
Left Lateral Rotation (0-30):	_____ to _____

Select all factors that cause this functional loss: ☐ N/A ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination

3C. REPEATED USE OVER TIME

Is the Veteran being examined immediately after repetitive use over time?

☐ Yes

☐ No

If the examination is ***not*** being conducted immediately after repetitive use over time:

☐ The examination is medically consistent with the Veteran's statements describing functional loss with repetitive use over time.

☐ The examination is medically inconsistent with the Veteran's statements describing functional loss with repetitive use over time.

☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss with repetitive use over time.

If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?

☐ Yes ☐ No ☐ Unable to say without mere speculation

If unable to say without mere speculation, please explain:

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

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

Select all factors that cause this functional loss: ☐ N/A ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination

Are you able to describe in terms of Range of Motion? ☐ Yes ☐ No

If no, please describe:

Forward Flexion (0-90):	_____	to _____	degrees
Extension (0-30):	_____	to _____	degrees
Right Lateral Flexion (0-30):	_____	to _____	degrees
Left Lateral Flexion (0- 30):	_____	to _____	degrees
Right Lateral Rotation (0-30):	_____	to _____	degrees
Left Lateral Rotation (0-30):	_____	to _____	degrees

3D. FLARE UPS

Is the examination being conducted during a flare up?

☐ Yes

☐ No

If the examination is ***not*** being conducted during a flare up:

☐ The examination is medically consistent with the Veteran's statements describing functional loss during flare up.

☐ The examination is medically inconsistent with the Veteran's statements describing functional loss during flare up. Please explain.

☐ The examination is neither medically consistent or inconsistent with the Veteran's statements describing functional loss during flare up.

If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:

Does pain, weakness, fatigability or incoordination significantly limit functional ability with flare ups?

☐ Yes ☐ No ☐ Unable to say without mere speculation

If unable to say without mere speculation, please explain:

Select all factors that cause this functional loss: ☐ N/A ☐ Pain ☐ Fatigue ☐ Weakness ☐ Lack of endurance ☐ Incoordination

Are you able to describe in terms of Range of Motion? ☐ Yes ☐ No

If no, please describe:

Forward Flexion (0-90):	_____	to _____	degrees
Extension (0-30):	_____	to _____	degrees
Right Lateral Flexion (0-30):	_____	to _____	degrees
Left Lateral Flexion (0- 30):	_____	to _____	degrees
Right Lateral Rotation (0-30):	_____	to _____	degrees
Left Lateral Rotation (0-30):	_____	to _____	degrees

3E. GUARDING AND MUSCLE SPASM

DOES THE VETERAN HAVE GUARDING OR MUSCLE SPASM OF THE THORACOLUMBAR SPINE *(back)*?

☐ YES ☐ NO

MUSCLE SPASM:

☐ NONE

☐ RESULTING IN ABNORMAL GAIT OR ABNORMAL SPINE CONTOUR

☐ NOT RESULTING IN ABNORMAL GAIT OR ABNORMAL SPINAL CONTOUR

☐ UNABLE TO EVALUATE, DESCRIBE BELOW:

PROVIDE DESCRIPTION AND/OR ETIOLOGY:

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

3E. GUARDING AND MUSCLE SPASM *(continued)*

GUARDING

- ☐ NONE
- ☐ RESULTING IN ABNORMAL GAIT OR ABNORMAL SPINE CONTOUR
- ☐ NOT RESULTING IN ABNORMAL GAINT OR ABNORMAL SPINAL CONTOUR
- ☐ UNABLE TO EVALUATE, DESCRIBE BELOW:

PROVIDE DESCRIPTION AND/OR ETIOLOGY:

3F. ADDITIONAL FACTORS CONTRIBUTING TO DISABILITY

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

- ☐ None
- ☐ Less movement than normal due to ankylosis, limitation or blocking, adhesions, etc.
- ☐ More movement than normal due to flail joints, fracture nonunion, etc.
- ☐ Weakened movement due to muscle or of peripheral nerves injury, etc.
- ☐ Other, describe:
- ☐ Swelling
- ☐ Deformity
- ☐ Atrophy of disuse
- ☐ Instability of station
- ☐ Disturbance of locomotion
- ☐ Interference with sitting
- ☐ Interference with standing

Please describe additional contributing factors of disability:

SECTION IV- MUSCLE STRENGTH TESTING

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

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

Side	Flexion/ Extension	Rate Strength	Flexion/ Extension	Rate Strength	Side	Flexion/ Extension	Rate Strength	Flexion/ Extension	Rate Strength
RIGHT	Hip Flexion	/5	Ankle Dorsiflexion	/5	LEFT	Hip Flexion	/5	Ankle Dorsiflexion	/5
	Knee Extension	/5	Great Toe Extension	/5		Knee Extension	/5	Great Toe Extension	/5
	Ankle Plantar Flexion	/5				Ankle Plantar Flexion	/5		

4B. 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

SECTION V - REFLEX EXAM

5. RATE DEEP TENDON REFLEXES (DTRs) ACCORDING TO THE FOLLOWING SCALE:

0 Absent
1+ Hypoactive
2+ Normal
3+ Hyperactive without clonus
4+ Hyperactive with clonus

RIGHT: KNEE: + ANKLE: +

LEFT: KNEE: + ANKLE: +

SECTION VI - SENSORY EXAM

6. PROVIDE RESULTS FOR SENSATION TO LIGHT TOUCH *(dermatome)* TESTING:

Side	Upper Anterior Thigh *(L2)*	Thigh/Knee *(L3/4)*	Lower Leg/Ankle *(L4/L5/S1)*	Foot/Toes *(L5)*
RIGHT	☐ Normal ☐ Decreased ☐ Absent	☐ Normal ☐ Decreased ☐ Absent	☐ Normal ☐ Decreased ☐ Absent	☐ Normal ☐ Decreased ☐ Absent
LEFT	☐ Normal ☐ Decreased ☐ Absent	☐ Normal ☐ Decreased ☐ Absent	☐ Normal ☐ Decreased ☐ Absent	☐ Normal ☐ Decreased ☐ Absent

OTHER SENSORY FINDINGS, IF ANY:

SECTION VII - STRAIGHT LEG RAISING TEST

NOTE: This test can be performed with the Veteran seated or supine. Raise each straightened leg until pain begins, typically at 30-70 degrees of elevation. The test is positive if the pain radiates below the knee, not merely limited to the back or hamstring muscles. Pain is often increased on dorsiflexion of the foot, and relieved by knee flexion. A positive test suggests radiculopathy, often due to disc herniation.

7. PROVIDE STRAIGHT LEG RAISING TEST RESULTS:

RIGHT: ☐ NEGATIVE ☐ POSITIVE ☐ UNABLE TO PERFORM

LEFT: ☐ NEGATIVE ☐ POSITIVE ☐ UNABLE TO PERFORM

SECTION VIII - RADICULOPATHY

DOES THE VETERAN HAVE RADICULAR PAIN OR ANY OTHER SIGNS OR SYMPTOMS DUE TO RADICULOPATHY?

☐ YES ☐ NO

IF YES, COMPLETE THE FOLLOWING SECTION:

8A. 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

8B. DOES THE VETERAN HAVE ANY OTHER SIGNS OR SYMPTOMS OF RADICULOPATHY?

☐ YES ☐ NO

IF YES, DESCRIBE:

SECTION VIII - RADICULOPATHY *(Continued)*

8C. INDICATE NERVE ROOTS INVOLVED *(check all that apply)*:

☐ INVOLVEMENT OF L2/L3/L4 NERVE ROOTS *(femoral nerve)*
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both

☐ INVOLVEMENT OF L4/L5/S1/S2/S3 NERVE ROOTS *(sciatic nerve)*
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both

☐ OTHER NERVES *(specify nerve and side(s) affected):*
If checked, indicate side affected: ☐ Right ☐ Left ☐ Both

8D. INDICATE SEVERITY OF RADICULOPATHY AND SIDE AFFECTED:

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

Right: ☐ Not affected ☐ Mild ☐ Moderate ☐ Severe
Left: ☐ Not affected ☐ Mild ☐ Moderate ☐ Severe

SECTION IX - ANKYLOSIS

9. IS THERE ANKYLOSIS OF THE SPINE?

☐ YES ☐ NO

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

SECTION X - OTHER NEUROLOGIC ABNORMALITIES

10. 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:

NOTE: If there are neurological abnormalities other than Radiculopathy, ALSO complete appropriate Questionnaire for each condition identified.

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

NOTE: IVDS is a group of signs and symptoms due to nerve root irritation that commonly includes back pain and sciatica (pain along the course of the sciatic nerve) in the case of lumbar disc disease, and neck and arm or hand pain in the case of cervical disc disease.

11A. DOES THE VETERAN HAVE IVDS OF THE THORACOLUMBAR SPINE?

☐ YES ☐ NO

11B. IF YES TO QUESTION 11A ABOVE, HAS THE VETERAN HAD ANY EPISODES OF ACUTE SIGNS AND SYMPTOMS DUE TO IVDS THAT REQUIRED BED REST PRESCRIBED BY A PHYSICAN AND TREATMENT BY A PHYSICAN IN THE PAST 12 MONTHS?

☐ YES ☐ NO

IF YES SELECT THE TOTAL DURATION OVER THE PAST 12 MONTHS:

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

11C. IF YES TO QUESTION 11B ABOVE, PROVIDE THE FOLLOWING DOCUMENTATION THAT SUPPORTS THE "YES" RESPONSE:

☐ MEDICAL HISTORY AS DESCRIBED BY THE VETERAN ONLY, WITHOUT DOCUMENTATION:

☐ MEDICAL HISTORY AS SHOWN AND DOCUMENTED IN THE VETERAN'S FILE:
INDIVIDUAL DATE(S) OF EACH TREATMENT RECORD(S) REVIEWED:

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

FACILITY/PROVIDER:

DESCRIBE TREATMENT:

☐ OTHER, DESCRIBE:

SECTION XII - ASSISTIVE DEVICES

12A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES AS A NORMAL MODE OF LOCOMOTION, ALTHOUGH OCCASIONAL LOCOMOTION BY OTHER METHODS MAY BE POSSIBLE?

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

☐ Wheelchair	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant	
☐ Brace	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant	
☐ Crutches	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant	
☐ Cane	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant	
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant	
☐ Other: _____	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant	

12B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION XIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

13. DUE TO THE VETERAN'S 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 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 XIV - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS AND SCARS

14A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☐ NO

IF YES, DESCRIBE (*brief summary*):

SECTION XIV - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS AND SCARS *(Continued)*

14B. 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.

14C. COMMENTS, IF ANY:

SECTION XV - DIAGNOSTIC TESTING

NOTE: The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.
Imaging studies are not required to make the diagnosis of IVDS; Electromyography (EMG) studies are rarely required to diagnose radiculopathy in the appropriate clinical setting.
For purposes of this examination, the diagnoses of IVDS and radiculopathy can be made by a history of characteristic radiating pain and/or sensory changes in the legs, and objective clinical findings, which may include the asymmetrical loss or decrease of reflexes, decreased strength and/or abnormal sensation.

15A. HAVE IMAGING STUDIES OF THE THORACOLUMBAR SPINE BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, IS ARTHRITIS DOCUMENTED?

☐ YES ☐ NO

15B. DOES THE VETERAN HAVE A THORACIC VERTEBRAL FRACTURE WITH LOSS OF 50 PERCENT OR MORE OF HEIGHT?

☐ YES ☐ NO

15C. 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)*:

SECTION XVI - FUNCTIONAL IMPACT

16. DOES THE VETERAN'S THORACOLUMBAR SPINE (BACK) CONDITION IMPACT 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:

SECTION XVII - REMARKS, IF ANY:

17. REMARKS, IF ANY:

SECTION XVIII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

18A. PHYSICIAN'S SIGNATURE	18B. PHYSICIAN'S PRINTED NAME	18C. DATE SIGNED

18D. PHYSICIAN'S PHONE NUMBER	18E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	18F. MEDICAL LICENSE AND STATE NUMBER

18G. PHYSICIAN'S ADDRESS