Department of Veterans Affairs

# INTERNAL VETERANS AFFAIRS USE
# NECK (CERVICAL 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 CERVIAL SPINE *(neck)* CONDITION?

☐ Yes ☐ No

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

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ Ankylosing apondylitis | ICD Code _____ | Date of diagnosis: _____ | ☐ Spinal fusion | ICD Code _____ | Date of diagnosis: _____ |
| ☐ Cervical strain | ICD Code _____ | Date of diagnosis: _____ | ☐ Spinal stenosis | ICD Code _____ | Date of diagnosis: _____ |
| ☐ Degenerative arthritis of the spine | ICD Code _____ | Date of diagnosis: _____ | ☐ Spondylolisthesis | ICD Code _____ | Date of diagnosis: _____ |
| ☐ Intervertebral disc syndrome | ICD Code _____ | Date of diagnosis: _____ | ☐ Vertebral dislocation | ICD Code _____ | Date of diagnosis: _____ |
| ☐ Segmental Instability | ICD Code _____ | Date of diagnosis: _____ | ☐ Vertebral fracture | ICD Code _____ | Date of diagnosis: _____ |

## SECTION I - DIAGNOSIS *(Continued)*

NOTE: PROVIDE ONLY DIAGNOSES THAT PERTAIN TO CERVIAL SPINE (NECK) CONDITIONS.*:*

☐ Other *(specify)*

| | | |
|---|---|---|
| Diagnosis # 1: | ICD code: | Date of diagnosis: |
| Diagnosis # 2: | ICD code: | Date of diagnosis: |
| Diagnosis # 3: | ICD code: | Date of diagnosis: |

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO CERVICAL SPINE *(neck)* CONDITIONS, LIST USING THE ABOVE FORMAT.

## SECTION II - MEDICAL HISTORY

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

2B. DOMINANT HAND:

☐ RIGHT ☐ LEFT ☐ AMBIDEXTROUS

2C. DOES THE VETERAN REPORT FLARE-UPS OF THE CERVICAL SPINE *(neck)*?

☐ YES ☐ NO

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

2D. DOES THE VETERAN REPORT HAVING ANY FUNCTIONAL LOSS OR FUNCTIONAL IMPAIRMENT OF THE CERVICAL SPINE *(neck) (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.

3A. INITIAL ROM MEASUREMENTS

☐ 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 (0-45): | ____ | to ____ | degrees | Left Lateral Flexion (0- 45): | ____ | to ____ | degrees |
| Extension (0-45): | ____ | to ____ | degrees | Right Lateral Rotation (0-80): | ____ | to ____ | degrees |
| Right Lateral Flexion (0-45): | ____ | to ____ | degrees | Left Lateral Rotation (0-80): | ____ | to ____ | degrees |

If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than a neck 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:

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

### 3A. INITIAL ROM MEASUREMENTS

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
- ☐ Extension
- ☐ Right Lateral Flexion
- ☐ Left Lateral Flexion
- ☐ Right Lateral Rotation
- ☐ 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 cervical spine (neck)? ☐ 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.

| Joint Movement | ROM after 3 repetitions: |
|---|---|
| Forward Flexion (0-45): | _____ to _____ |
| Extension (0-45): | _____ to _____ |
| Right Lateral Flexion (0-45): | _____ to _____ |
| Left Lateral Flexion (0- 45): | _____ to _____ |
| Right Lateral Rotation (0-80): | _____ to _____ |
| Left Lateral Rotation (0-80): | _____ 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:

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 (0-45): | _____ | to _____ | degrees |
| Extension (0-45): | _____ | to _____ | degrees |
| Right Lateral Flexion (0-45): | _____ | to _____ | degrees |
| Left Lateral Flexion (0- 45): | _____ | to _____ | degrees |
| Right Lateral Rotation (0-80): | _____ | to _____ | degrees |
| Left Lateral Rotation (0-80): | _____ | to _____ | degrees |

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

3D. FLARE UPS

| Is the examination being conducted during a flare up? | If the examination is ***not*** being conducted during a flare up: | If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain: |
|---|---|---|
| ☐ Yes<br>☐ No | ☐ The examination is medically consistent with the Veteran's statements describing functional loss during flare up.<br>☐ The examination is medically inconsistent with the Veteran's statements describing functional loss during flare up. Please explain.<br>☐ 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? | If unable to say without mere speculation, please explain: |
|---|---|
| ☐ Yes ☐ No ☐ Unable to say without mere speculation | |

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 (0-45): _____ to _____ degrees | |
| Extension (0-45): _____ to _____ degrees | |
| Right Lateral Flexion (0-45): _____ to _____ degrees | |
| Left Lateral Flexion (0- 45): _____ to _____ degrees | |
| Right Lateral Rotation (0-80): _____ to _____ degrees | |
| Left Lateral Rotation (0-80): _____ to _____ degrees | |

3E. GUARDING AND MUSCLE SPASM

DOES THE VETERAN HAVE LOCALIZED TENDERNESS, GUARDING OR MUSCLE SPASM OF THE CERVICAL SPINE *(neck)*?

☐ 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:

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:

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

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, tendon-tie-ups, contracted scars, etc.)*
- ☐ More movement than normal *(from flail joints, resections, nonunion of fractures, relaxation of ligaments, etc..)*
- ☐ Weakened movement *(due to muscle injury, disease or injury of peripheral nerves, divided or lengthened tendons, etc.)*
- ☐ Swelling
- ☐ Deformity
- ☐ Atrophy of disuse
- ☐ Instability of station
- ☐ Disturbance of locomotion
- ☐ Interference with sitting
- ☐ Interference with standing
- ☐ Other, describe:

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 | Elbow Flexion | /5 | Wrist Extension | /5 | LEFT | Elbow Flexion | /5 | Wrist Extension | /5 |
| | Elbow Extension | /5 | Finger Flexion | /5 | | Elbow Extension | /5 | Finger Flexion | /5 |
| | Wrist Flexion | /5 | Finger Abduction | /5 | | Wrist Flexion | /5 | Finger Abduction | /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: | BICEP: | + | TRICEP: | + | Brachoradialis: | + | |
| LEFT: | BICEP: | + | TRICEP: | + | Brachoradialis: | + | |

## SECTION VI - SENSORY EXAM

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

| Side | Shoulder Area *(C5)* | Inner/Outer Forearm *(C6-T1)* | Hand/Fingers *(C6-8)* |
|---|---|---|---|
| RIGHT | ☐ Normal ☐ Decreased ☐ Absent | ☐ Normal ☐ Decreased ☐ Absent | ☐ Normal ☐ Decreased ☐ Absent |
| LEFT | ☐ Normal ☐ Decreased ☐ Absent | ☐ Normal ☐ Decreased ☐ Absent | ☐ Normal ☐ Decreased ☐ Absent |

OTHER SENSORY FINDINGS, IF ANY:

## SECTION VII - RADICULOPATHY

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

☐ YES ☐ NO

IF YES, COMPLETE THE FOLLOWING SECTION:

7A. INDICATE SYMPTOMS' LOCATION AND SEVERITY *(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 |

7B. DOES THE VETERAN HAVE ANY OTHER SIGNS OR SYMPTOMS OF RADICULOPATHY?

☐ YES ☐ NO

IF YES, DESCRIBE:

7C. INDICATE NERVE ROOTS INVOLVED *(check all that apply)*:

☐ INVOLVEMENT OF C5/C6 NERVE ROOTS *(upper radicular group)*

If checked, indicate: ☐ Right ☐ Left ☐ Both

☐ INVOLVEMENT OF C7 NERVE ROOT *(middle radicular group)*

If checked, indicate: ☐ Right ☐ Left ☐ Both

☐ INVOLVEMENT OF C8/T1 NERVE ROOTS *(lower radicular group):*

If checked, indicate: ☐ Right ☐ Left ☐ Both

7D. 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 VIII - ANKYLOSIS

8. IS THERE ANKYLOSIS OF THE SPINE?

☐ YES ☐ NO

☐ Unfavorable ankylosis of the entire spine

☐ Unfavorable ankylosis of the entire cervical spine

☐ Favorable ankylosis of the entire cervical spine

## SECTION IX - OTHER NEUROLOGIC ABNORMALITIES

9. 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:

**NOTE:** ALSO complete appropriate Questionnaire, if indicated.

## SECTION X - 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.

10A. DOES THE VETERAN HAVE IVDS OF THE CERVICAL SPINE?

☐ YES ☐ NO

10B. IF YES TO QUESTION 10A 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

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

10C. IF YES TO QUESTION 10B 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:

FACILITY/PROVIDER:

DESCRIBE TREATMENT:

☐ OTHER, DESCRIBE:

## SECTION XI - ASSISTIVE DEVICES

11A. 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 | |

11B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

## SECTION XII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

12. DUE TO THE VETERAN'S 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., 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 UPPER ☐ LEFT UPPER

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 XIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS AND SCARS

13A. 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 XIII - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS AND SCARS *(Continued)*

13B. 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.

13C. COMMENTS, IF ANY:

## SECTION XIV - DIAGNOSTIC TESTING

**NOTE:** 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 diagnoses of IVDS and 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.

14A. 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

14B. DOES THE VETERAN HAVE A CERVICAL VERTEBRAL FRACTURE WITH LOSS OF 50 PERCENT OR MORE OF HEIGHT?

☐ YES ☐ NO

14C. 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 XV - FUNCTIONAL IMPACT

15. DOES THE VETERAN'S CERVICAL SPINE (NECK) CONDITION IMPACT 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:

## SECTION XVI - REMARKS

16. REMARKS, IF ANY:

## SECTION XVII - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

| 17A. PHYSICIAN'S SIGNATURE | 17B. PHYSICIAN'S PRINTED NAME | 17C. DATE SIGNED |
|---|---|---|
| | | |

| 17D. PHYSICIAN'S PHONE NUMBER | 17E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER | 17F. MEDICAL LICENSE NUMBER AND STATE |
|---|---|---|
| | | |

17G. PHYSICIAN'S ADDRESS