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:	SSN:	EXAMINATION DATE:
[redacted]	[redacted]	1/20/2017

NOTE TO PHYSICIAN: The Veteran or Service Member 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 claim. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.

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 DBQ and such an examination will likely provide no additional relevant evidence.

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

☐ Examination via approved video telehealth

☒ In-person examination

EVIDENCE REVIEW

WAS THE VETERAN'S VA E-FOLDER (VBMS OR VIRTUAL VA) REVIEWED?

☒ YES ☐ NO

WAS THE VETERAN'S VA CLAIMS FILE (HARD COPY PAPER C-FILE) REVIEWED?

☐ YES ☒ NO

IF YES, LIST ANY RECORDS THAT WERE REVIEWED BUT WERE NOT INCLUDED IN THE VETERAN'S VA CLAIMS FILE:

N/A

IF NO, CHECK ALL RECORDS REVIEWED:

☐ Military service treatment records
☐ Military service personnel records
☐ Military enlistment examination
☐ Military separation examination
☐ Military post-deployment questionnaire
☐ No records were reviewed
☐ Department of Defense Form 214 Separation Documents
☐ Veterans Health Administration medical records *(VA treatment records)*
☐ Civilian medical records
☐ Interviews with collateral witnesses *(family and others who have known the Veteran before and after military service)*
☐ Other:

WAS PERTINENT INFORMATION FROM COLLATERAL SOURCES REVIEWED?

☐ YES ☒ NO

IF YES, DESCRIBE:

LHI

BACK (THORACOLUMBAR SPINE) CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

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.)

☐ Ankylosing spondylitis	ICD Code:	Date of diagnosis:
☐ Lumbosacral strain	ICD Code:	Date of diagnosis:
☒ Degenerative arthritis of the spine	ICD Code: M47.819	Date of diagnosis: 1/20/2017
☐ Intervertebral disc syndrome	ICD Code:	Date of diagnosis:
☐ Sacroiliac injury	ICD Code:	Date of diagnosis:
☐ Sacroiliac weakness	ICD Code:	Date of diagnosis:
☐ Segmental instability	ICD Code:	Date of diagnosis:
☐ Spinal fusion	ICD Code:	Date of diagnosis:
☐ Spinal stenosis	ICD Code:	Date of diagnosis:
☐ Spondylolisthesis	ICD Code:	Date of diagnosis:
☐ Vertebral dislocation	ICD Code:	Date of diagnosis:
☐ Vertebral fracture	ICD Code:	Date of diagnosis:
☐ Other, (specify)		
Diagnosis #1:	ICD Code:	Date of diagnosis:
Diagnosis #2:	ICD Code:	Date of diagnosis:
Diagnosis #3:	ICD Code:	Date of diagnosis:

1C. COMMENTS (*If any*):

1D. WAS AN OPINION REQUESTED ABOUT THIS CONDITION?

☐ YES ☐ NO ☒ N/A

SECTION II - MEDICAL HISTORY

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

Onset:

Hx of overexertion from working as flight deck personell, which entails heavy lifting x 4+ years. Hx of lower back pain since 2002. Denies hospitalizations/surgeries. Hx of physical therapy sessions from 9/3/2015 x 1 year.

Current Symptoms:

Currently reports constant dull aching mid-lower back pain with numbness and tingling with bilateral feet L> R parasthesia aggravted by running and sitting for long periods of time.

Current Treatment/Frequency:

Treatment includes Tylenol & Motrin PRN

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

Measure ROM with a goniometer. During the examination be cognizant of painful motion, which could be evidenced by visible behavior such as facial expression, wincing, etc..., on pressure or manipulation.

Following the initial assessment of ROM, perform repetitive use testing. For VA purposes, repetitive use testing must be included in all joint exams. The VA has determined that 3 repetitions of ROM (at a 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 question 3.

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
☒ Abnormal or outside of normal range
☐ Unable to test (please explain)
☐ Not indicated (please explain)

If "Unable to test" or "Not indicated", please explain:

Forward Flexion (0-90):	0	to 40	degrees	Left Lateral Flexion (0-30):	0	to 15	degrees
Extension (0-30):	0	to 15	degrees	Right Lateral Rotation (0-30):	0	to 15	degrees
Right Lateral Flexion (0-30):	0	to 15	degrees	Left Lateral Rotation (0-30):	0	to 15	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):	If noted on examination, which ROM exhibited pain (select all that apply):		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
☐ No pain noted on exam	☒ Forward Flexion	☒ Left Lateral Flexion	If YES, describe include location, severity and relationship to condition(s).
☐ Pain noted on exam on rest / non-movement	☒ Extension	☒ Right Lateral Rotation	
☐ Pain noted on exam but does not result in / cause functional loss	☒ Right Lateral Flexion	☒ Left Lateral Rotation	
☒ Pain noted on examination and causes functional loss	Is there evidence of pain with weight bearing? ☐ YES ☒ NO		

3B. OBSERVED REPETITIVE USE

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:
☒ YES ☐ NO	☐ YES ☒ NO	Forward Flexion (0-90):	to
If YES, perform repetitive-use testing	If YES, report ROM after a minimum of 3 repetitions.	Extension (0-30):	to
If NO, please provide reason:	If NO, documentation of ROM after repetitive-use testing is not required.	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?	If the examination is not being conducted immediately after repetitive use over time:	If the examination is medically inconsistent with the Veteran's statements of functional loss, please explain:
☐ YES ☒ NO	☐ 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.	

Does pain, weakness, fatigability or incoordination significantly limit functional ability with repeated use over a period of time?	If unable to say without mere speculation, please explain:
☐ YES ☐ NO ☒ Unable to say without mere speculation	There is no conceptual or empirical basis for making such a determination without directly observing function under these conditions.

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	It is not possible to determine, without resorting to mere speculation, to estimate loss of range of motion, because there is no conceptual or empirical basis for making such a determination without directly observing function under these conditions.
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?	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 ☒ NO	☐ 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.	

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	There is no conceptual or empirical basis for making such a determination without directly observing function under the flare up condition.

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	It is not possible to determine, without resorting to mere speculation, to estimate loss of range of motion, because there is no conceptual or empirical basis for making such a determination without directly observing function under these conditions.
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:

LOCALIZED TENDERNESS:

- ☐ 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 GAIT 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, 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.)
- ☐ 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	Side	Flexion/Extension	Rate Strength
RIGHT	Hip Flexion	5/5	LEFT	Hip Flexion	5/5
	Knee Extension	5/5		Knee Extension	5/5
	Ankle Plantar Flexion	5/5		Ankle Plantar Flexion	5/5
	Ankle Dorsiflexion	5/5		Ankle Dorsiflexion	5/5
	Great Toe Extension	5/5		Great Toe Extension	5/5

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: 3+ ANKLE: 2+

LEFT: KNEE: 2+ ANKLE: 1+

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:

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 INCAPACITATING EPISODES

NOTE: For VA purposes, 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:

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., 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)*:

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*):

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?

☐ 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: 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. 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*):

04/02/2014 MRI LUMABR- MULTILEVEL DEGENERATIVE DISC DISEASE / LUMBAR SPONDYLOSIS

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

17. REMARKS, IF ANY:
Joint testing per Correia v. McDonald July 5, 2016 No. 13-3238 requirements was performed as medically appropriate.
X-rays on the day of exam were not clinically indicated

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
Christina Fasanmi Digitally Signed 01/23/2017 11:01:39 AM Nurse Practitioner	Christina Fasanmi, NP	1/23/2017

18D. PHYSICIAN'S PHONE NUMBER	18E. PHYSICIAN'S MEDICAL LICENSE NUMBER	18F. PHYSICIAN'S ADDRESS
[redacted]	[redacted]	4201 Northview Drive Suite 410 Bowie MD 20716

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

If questions or issues arise upon review of this Examination, please contact the VA Medical Center or DOD facility that processed the request for examination.
Contractor: Logistics Health Incorporated

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. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

Name of patient/Veteran: [redacted] **SSN:** [redacted]
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.

Examination Date: 1/20/2017

1. DEFINITIONS

Aggravation of preexisting nonservice-connected disabilities. A preexisting injury or disease will be considered to have been aggravated by active military, naval, or air service, where there is an increase in disability during such service, unless there is a specific finding that the increase in disability is due to the natural progress of the disease.

Aggravation of nonservice-connected disabilities. Any increase in severity of a nonservice-connected disease or injury that is proximately due to or the result of a service-connected disease or injury, and not due to the natural progress of the nonservice-connected disease, will be service connected.

2. RESTATEMENT OF REQUESTED OPINION

a. Insert requested opinion from general remarks:

Does the Veteran have a diagnosis of (a) Back condition that is at least as likely as not (50 percent or greater probability) incurred in or caused by (the) Noted back pain in STRs during service?

b. Indicate type of exam for which opinion has been requested (e.g. Skin Diseases):

Back condition

3. EVIDENCE REVIEW

a. Was the Veteran's VA claims file reviewed?

☒ Yes ☐ No

If YES, list any records that were reviewed but were not included in the Veteran's VA claims file:

N/A

If NO, check all records reviewed:

- ☐ Military service treatment records
- ☐ Military service personnel records
- ☐ Military enlistment examination
- ☐ Military separation examination
- ☐ Military post-deployment questionnaire
- ☐ Department of Defense Form 214 Separation Documents

☐ Veterans Health Administration medical records (VA treatment records)
☐ Civilian medical records
☐ Interviews with collateral witnesses (family and others who have known the veteran before and after military service)
☐ No records were reviewed
☐ Other:

Complete only the sections below that you are asked to complete in the Medical Opinion DBQ request.

4. MEDICAL OPINION FOR DIRECT SERVICE CONNECTION

a. Choose the statement that most closely approximates the etiology of the claimed condition.

☒ The claimed condition was at least as likely as not (50 percent or greater probability) incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale below.
☐ The claimed condition was less likely than not (less than 50 percent probability) incurred in or caused by the claimed in-service injury, event, or illness. Provide rationale:

Veteran had no issues related to the claimed condition prior to military service. Onset of the condition was during service, documented in the Service Medical Records. There is evidence of current, chronic and continuous treatment and care. A nexus has been established.

5. MEDICAL OPINION FOR SECONDARY SERVICE CONNECTION

☐ The claimed condition is at least as likely as not (50 percent or greater probability) proximately due to or the result of the Veteran's service connected condition. Provide rationale below.
☐ The claimed condition is less likely than not (less than 50 percent probability) proximately due to or the result of the Veteran's service connected condition. Provide rationale:

6. MEDICAL OPINION FOR AGGRAVATION OF A CONDITION THAT EXISTED PRIOR TO SERVICE

☐ The claimed condition, which clearly and unmistakably existed prior to service, was aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale below.

☐ The claimed condition, which clearly and unmistakably existed prior to service, was clearly and unmistakably not aggravated beyond its natural progression by an in-service injury, event, or illness. Provide rationale:

7. MEDICAL OPINION FOR AGGRAVATION OF A NONSERVICE CONNECTED CONDITION BY A SERVICE CONNECTED CONDITION

a. Can you determine a baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition)?
☐ Yes ☐ No
If YES to question 7a, answer the following:

Describe the baseline level of severity of (claimed condition/diagnosis) based upon medical evidence available prior to aggravation or the earliest medical evidence following aggravation by (service connected condition):

Provide the date and nature of the medical evidence used to provide the baseline:

Is the current severity of the (claimed condition/diagnosis) greater than the baseline?
☐ Yes ☐ No
If YES, was the Veteran's (claimed condition/diagnosis) at least as likely as not aggravated beyond its natural progression by the service connected condition?
☐ Yes (provide rationale in section b.)
☐ No (provide rationale in section b.)

If NO to question 7a, answer the following:

Provide rationale as to why a baseline cannot be established (e.g. medical evidence is not sufficient to support a determination of a baseline level of severity):

Regardless of an established baseline, was the Veteran's (claimed condition/diagnosis) at least as likely as not aggravated beyond its natural progression by service connected condition?

☐ Yes (provide rationale in section b.)
☐ No (provide rationale in section b.)

b. Provide rationale:

8. OPINION REGARDING CONFLICTING MEDICAL EVIDENCE

I have reviewed the conflicting medical evidence and am providing the following opinion:

9. INDIVIDUAL UNEMPLOYABILITY STATEMENT

It is as least as likely as not (50 percent or greater probability) that related to the Veteran's service connected condition(s) the Veteran IS ABLE TO PERFORM the following in a normal 8 hour work day:

(Occasional < 1/3 of Work Day; Frequent Between 1/3 and 2/3 of Work Day; Constant > 2/3 of Work Day)

☐ **No restrictions for job activities required**
☐ **Sedentary work**
Exerting up to 10 pounds of force occasionally and/or a negligible amount of force frequently to lift, carry, push, pull. Sedentary work involves sitting most of the time, but may involve walking or standing for brief periods of time. Jobs are sedentary if walking and standing are required only occasionally and all other sedentary criteria are met.
☐ **Light work**
Exerting up to 20 pounds of force occasionally, and/or up to 10 pounds of force frequently, and/or a negligible amount of force constantly to move objects. Physical demand requirements are in excess of those for Sedentary Work. Even though the weight lifted may be only a negligible amount, a job should be rated Light Work: (1) when it requires walking or standing to a significant degree; or (2) when it requires sitting most of the time but entails pushing and/or pulling of arm or leg controls; and/or (3) when the job requires working at a production rate pace entailing the constant pushing and/or pulling of materials even though the weight of those materials is negligible.

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☐ **Medium work**
Exerting 20 to 50 pounds of force occasionally, and/or 10 to 25 pounds of force frequently, and/or greater than negligible up to 10 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Light Work.

☐ **Heavy work (Strenuous)**
Exerting 50 to 100 pounds of force occasionally, and/or 25 to 50 pounds of force frequently, and/or 10 to 20 pounds of force constantly to move objects. Physical Demand requirements are in excess of those for Medium Work.

☐ **Unable to perform sedentary work**

☐ **Other:**

10. REMARKS, IF ANY

Physician printed name: Christina Fasanmi, NP

Date: 1/23/2017

Physician signature: Christina Fasanmi Digitally Signed 01/23/2017 11:01:43 AM

Medical license [redacted]

Physician address: 4201 Northview Drive Suite 410 Bowie MD 20716

Phone: [redacted]

Fax: [redacted]

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