Back (Thoracolumbar Spine) Conditions
Disability Benefits Questionnaire

Name of Patient/Veteran: **RAMSEY, JUBAR D**
Patient/Veteran Social Security Number: **220-27-1013**

Is this DBQ being completed in conjunction with a VA21-2507, C&P examination request?

☒ Yes ☐ No

If no, how was the examination completed (check all that apply)?

☐ In-person examination
☐ Records reviewed
☐ Other, please specify:

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 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

Evidence Reviewed (check all that apply):

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

List the claimed conditions(s) that pertain to this DBQ:

Exam: Lumbar spine condition

NOTE: These are the diagnoses determined during this **current** evaluation of the claimed condition(s) listed above. If there is "No diagnosis", or if the diagnosis is different from a previous diagnosis for this condition, if there is a diagnosis of a complication due to the claimed condition, explain your findings and reasons in the 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.

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 Spondylitis	ICD Code: M45	Date of Diagnosis:
☒ Lumbosacral strain	ICD Code: S33	Date of Diagnosis: 2011
☐ Degenerative arthritis of the spine	ICD Code: M47	Date of Diagnosis:
☐ Intervertebral disc syndrome	ICD Code: M51	Date of Diagnosis:
☐ Segmental instability	ICD Code: M24	Date of Diagnosis:
☐ Spinal fusion	ICD Code: M43	Date of Diagnosis:
☐ Spinal stenosis	ICD Code: M48	Date of Diagnosis:
☐ Spondylolisthesis	ICD Code: M43	Date of Diagnosis:
☐ Sacroiliac injury	ICD Code:	Date of Diagnosis:
☐ Sacroiliac weakness	ICD Code:	Date of Diagnosis:
☐ Vertebral dislocation	ICD Code: M43	Date of Diagnosis:
☐ Vertebral fracture	ICD Code: S32	Date of Diagnosis:

1C. If there are additional diagnoses 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):

The Veteran c/o lower back pain started when he was wearing gear in 2011. He notes no x-ray was done, but he did received Motrin for pain as needed. He stated that he continues to have

intermittent pain most of the day, severity of pain 6/10 and Pain is worse if he wears back-pack, lifting and increase exercise like bending. The Pain is better with Tylenol but Pain is minimally relived with Tylenol.

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**:

Pain Flare-up when he lifts something heavy and with bending

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**:

Pain with lifting, bending and squating

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 Range of Motion

ROM All Normal

☐ Yes ☒ No

If no, please select below:

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

Forward Flexion

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40
☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65 ☐ 70 ☒ 75 ☐ 80 ☐ 85
☐ 90 or greater

Extension

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☒ 25 ☐ 30 or greater

Right Lateral Flexion

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☒ 25 ☐ 30 or greater

Left Lateral Flexion

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☒ 20 ☐ 25 ☐ 30 or greater

Right Lateral Rotation

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☒ 20 ☐ 25 ☐ 30 or greater

Left Lateral Rotation

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☒ 20 ☐ 25 ☐ 30 or greater

3Ai. If "Unable to test" or "Not indicated", please explain:

3Aii. If abnormal, does the range of motion itself contribute to a functional loss?

☒ Yes (If yes, please explain)
☐ No

The abnormal ROM were caused by pain is worse with flexion

3Aiii.

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:

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 thoracolumbar spine(back)?

☒ Yes ☐ No

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

Thoracic

8/10

Consistent with complaints of back pain/strain

☒ Correia Exam Requirement

1. Is there evidence of pain on passive range of motion testing?
   ☐ Yes ☒ No ☐ Cannot be performed or is not medically appropriate
2. Is there evidence of pain when the joint is used in non-weight bearing?
   ☐ Yes ☒ No ☐ Cannot be performed or is not medically appropriate
3. If yes, is the opposing joint undamaged (i.e. no abnormalities)?
   ☐ Yes ☐ No ☐ N/A; there is no opposing joint

If yes, conduct range of motion testing for the opposing joint and provide ROM measurements.

If no, the examiner is requested to state whether it is medically feasible to test the joint and if not to please state why the examiner cannot test the range of motion of the opposing joint.

3B. Observed Repetitive Use

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

☒ Yes (**If yes**, perform repetitive-use testing)

☐ No (**If no**, provide reason below)

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

☒ Yes, report ROM after a minimum of 3 repetitions

☐ No, (documentation of ROM after repetitive-use testing is not required)

ROM after 3 repetitions:

Forward flexion ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40
☐ 45 ☐ 50 ☐ 55 ☐ 60 ☒ 65 ☐ 70 ☐ 75 ☐ 80 ☐ 85
☐ 90 or greater

Extension ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☒ 20 ☐ 25 ☐ 30 or greater

Right lateral flexion ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☒ 20 ☐ 25 ☐ 30 or greater

Left lateral flexion ends:

☐ 0 ☐ 5 ☐ 10 ☒ 15 ☐ 20 ☐ 25 ☐ 30 or greater

Right lateral rotation ends:

☐ 0 ☐ 5 ☐ 10 ☒ 15 ☐ 20 ☐ 25 ☐ 30 or greater

Left lateral rotation ends:

☐ 0 ☐ 5 ☐ 10 ☒ 15 ☐ 20 ☐ 25 ☐ 30 or greater

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 ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40
☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65 ☐ 70 ☐ 75 ☐ 80 ☐ 85
☐ 90 or greater

Extension ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

Right lateral flexion ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

Left lateral flexion ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

Right lateral rotation ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

Left lateral rotation ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

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.

☒ 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 ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40
☐ 45 ☐ 50 ☐ 55 ☐ 60 ☐ 65 ☐ 70 ☐ 75 ☐ 80 ☐ 85
☐ 90 or greater

Extension ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

Right lateral flexion ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

Left lateral flexion ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

Right lateral rotation ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

Left lateral rotation ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 or greater

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:

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 etc.
☐ More movement than normal due to flail joints, fracture nonunion, etc.)
☒ Weakened movement due to muscle or of peripheral nerves injury, 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

Hip Flexion:	Right	☒ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left	☒ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Knee Extension:	Right	☐ 5/5	☒ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left	☒ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Ankle plantar flexion:	Right	☒ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left	☒ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Ankle dorsiflexion:	Right	☒ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left	☒ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
Great Toe Extension:	Right	☒ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5
	Left	☒ 5/5	☐ 4/5	☐ 3/5	☐ 2/5	☐ 1/5	☐ 0/5

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

5A. Rate deep tendon reflexes (DTRs) according to the following scale:

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

Knee:	Right	☐ 0	☐ 1+	☒ 2+	☐ 3+	☐ 4+
	Left	☐ 0	☐ 1+	☒ 2+	☐ 3+	☐ 4+
Ankle:	Right	☐ 0	☐ 1+	☒ 2+	☐ 3+	☐ 4+
	Left	☐ 0	☐ 1+	☒ 2+	☐ 3+	☐ 4+

Section VI - Sensory Exam

6A. Provide results for sensation to light touch (dermatome) testing:

Upper Anterior Thigh *(L2)*	Right	☒ Normal	☐ Decreased	☐ Absent
	Left	☒ Normal	☐ Decreased	☐ Absent
Thigh/Knee	Right	☒ Normal	☐ Decreased	☐ Absent
	Left	☒ Normal	☐ Decreased	☐ Absent
Lower Leg/Ankle	Right	☒ Normal	☐ Decreased	☐ Absent
	Left	☒ Normal	☐ Decreased	☐ Absent
Foot/Toes	Right	☒ Normal	☐ Decreased	☐ Absent
	Left	☒ Normal	☐ Decreased	☐ Absent

6B. 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.

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

Indicate symptoms' location and severity (check all that apply):

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 relfexes?)

☐ 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 physician and treatment by a physician 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(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutch(es)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane(s)	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Walker	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Other:	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

12B. If the Veteran uses any assistive devices, specify the diagnosis/condition and identify the assistive device used for each condition:

Section XIII - Remaining Effective Function Of The Extremities

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? (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 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):

X-ray Lumbosacral spine 08/11/2017

Results for lumbosacral spine are normal

X-ray Thoracic spine 08/11/2017

Unremarkable exam

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 functional impact of each of the veteran's thoracolumbar spnine (back) conditions, providing one or more examples:

Veteran is limited by bending, pulling, reaching, pushing, limitation with weight lifting
The Veteran can only perform Light Physical and Sedentary task due to his diagnosis.

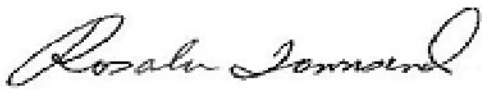
VBMS was reviewed

Section XVII - Remarks, If Any:

There are no pertinent medical records for the complaint, symptomatology or diagnosis of the condition

Section XVIII - Physician's Certification and Signature

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



Rosalee Townsend, MSN	
Signed:	08/23/2017
National Provider Identifier (NPI) Number:	1598033367
Specialty:	Family Medicine
Address:	1145 19th Street NW Suite 506 Washington, DC 20036
Phone:	(626) 407-2151
Fax:	(626) 701-5154

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 voluntary. 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 15 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.

GWU- George Washington University Hospital
Washington, DC 20037-2342
(202) 715-4000

Patient: RAMSEY, JUBAR DONTE
Ordering Physician: Nolte,Elizabeth MD
Attending Physician: Nolte,Elizabeth MD

Patient Type: Outpatient

Date of Birth: 2/20/1990
Patient Location: GWU 19 ST OIC

Imaging

PROCEDURE
XR Spine Thoracic 2 Views

EXAM DATE/TIME
8/11/2017 11:12 EDT

PROCEDURE: XR SPINE THORACIC 2 VIEWS

COMPARISON: None.

INDICATIONS: back pain

FINDINGS:
VIEWS: AP and lateral views of the thoracic spine were performed.

ALIGNMENT: There is normal alignment of the vertebral bodies.

BONES \T\ DISCS: The vertebral bodies are intact. The disc spaces are maintained.

SOFT TISSUES: Soft tissues are unremarkable.

IMPRESSION:

Unremarkable examination.

Dictated by: Joanna Riess, M.D. on 8/11/2017 at 11:28
Final report has been approved and electronically signed by: Joanna Riess, M.D. on 8/11/2017 at 11:28
***** Final *****

Dictated by: Riess, Joanna S MD *Dictated DT/TM: 08/11/2017 11:28 am*
Transcribed By: JSRTranscribed by: JSR *Transcribed DT/TM: 08/11/17 11:28:57*
Electronically Signed by: Riess, Joanna S MD *Signed DT/TM: 08/11/2017 11:28 am*

MRN: GWU4438115 FIN: GWU0000131975443 Accession Number: 55-XR-17-070344 Page 1 of 1
Report Request Id: 94673857

GWU- George Washington University Hospital
Washington, DC 20037-2342
(202) 715-4000

Patient: RAMSEY, JUBAR DONTE
Ordering Physician: Nolte,Elizabeth MD
Attending Physician: Nolte,Elizabeth MD
Patient Type: Outpatient
Date of Birth: 2/20/1990
Patient Location: GWU 19 ST OIC

Imaging

PROCEDURE
XR Chest 2 Views

EXAM DATE/TIME
8/11/2017 11:12 EDT

PROCEDURE: XR CHEST 2 VIEWS

COMPARISON: None.

INDICATIONS: Back pain

FINDINGS:

PA and lateral views of the chest were performed.

HEART AND MEDIASTINUM: The cardiomediastinal silhouette is normal.

PLEURA: No pleural effusion or pneumothorax.

LUNGS: The lungs are clear.

BONES: No acute abnormality.

IMPRESSION:

No evidence of acute cardiopulmonary findings.

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Dictated by: Joanna Riess, M.D. on 8/11/2017 at 11:25
Final report has been approved and electronically signed by: Joanna Riess, M.D. on 8/11/2017 at 11:26
***** *Final* *****

Dictated by: Riess, Joanna S MD *Dictated DT/TM: 08/11/2017 11:26 am*
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MRN: GWU4438115 FIN: GWU0000131975443 Accession Number: 55-XR-17-070345 Page 1 of 1
Report Request Id: 94673458

GWU- George Washington University Hospital
Washington, DC 20037-2342
(202) 715-4000

Patient: RAMSEY, JUBAR DONTE
Date of Birth: 2/20/1990
Ordering Physician: Nolte,Elizabeth MD
Patient Type: Outpatient
Patient Location: GWU 19 ST OIC
Attending Physician: Nolte,Elizabeth MD

Imaging

PROCEDURE
XR Spine Lumbosacral 2 or 3 Views

EXAM DATE/TIME
8/11/2017 11:12 EDT

PROCEDURE: XR SPINE LUMBOSACRAL 2 OR 3 VIEWS

COMPARISON: None.

INDICATIONS: back pain

FINDINGS:
VIEWS: x views of the lumbar spine were performed.

ALIGNMENT: There is normal alignment of the vertebral bodies.

BONES \T\ DISCS: The vertebral bodies are intact. The disc spaces are maintained.

SOFT TISSUES: Soft tissues are unremarkable.

IMPRESSION:

Unremarkable examination.

Dictated by: Joanna Riess, M.D. on 8/11/2017 at 11:29
Final report has been approved and electronically signed by: Joanna Riess, M.D. on 8/11/2017 at 11:29

***** *Final* *****

Dictated by: *Riess, Joanna S MD* *Dictated DT/TM:* *08/11/2017 11:29 am*
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Electronically Signed by: *Riess, Joanna S MD* *Signed DT/TM:* *08/11/2017 11:29 am*

MRN: GWU4438115 FIN: GWU0000131975443 Accession Number: 55-XR-17-070343 Page 1 of 1
Report Request Id: 94673892