Veterans Affairs Canada | Anciens Combattants Canada

Protected information when completed.

File No.:	Decision No.:
	Service No(s).:

Medical Questionnaire: Musculoskeletal Cervical Spine Conditions

Family name:	Given name:	Date of Birth:
Name of Physician:		Date of Examination:

MEDICAL DIAGNOSIS(ES) OF CLAIMED/PENSIONED CONDITION(S) REQUIRING EXAMINATION:

1. _____

Is this diagnosis: ◯ ◯

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

2. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

3. _____

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No
If yes, please comment and include approximate time frame:

Very specific information is required by Veterans Affairs Canada to evaluate and assess a client's claimed pensioned condition(s). As this information may not generally form part of the clinical history, please help us to collect this information by answering the following questions.

Please complete applicable sections only.

If additional recording space is required, please use the "additional comments" sheet.

MEDICAL HISTORY: Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors.

Does the client have radicular pain? ◯ Yes ◯ No
If yes, please describe and indicate frequency:

Cervical injuries? ◯ Yes ◯ No **Describe (include dates)**

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No
If yes, indicate for which condition (if more than one) and indicate the nature of the test/consultation, and the appointment date (if known):

PLEASE ATTACH/FORWARD COPIES OF RELEVANT REPORTS (E.G. DIAGNOSTIC, CONSULTATION, OPERATIVE, LABORATORY, HOSPITAL DISCHARGE SUMMARIES)

Family name:	Given name:	File No.:

TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response), details of relevant surgery/hospitalization and other therapies (e.g. physiotherapy).

COMPLICATIONS:

Are there any complications resulting from the claimed/pensioned condition(s)? ◯ Yes ◯ No

If yes, please provide details:

PHYSICAL EXAMINATION: (fill out only portion applicable to the pensioned/claimed condition(s))

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Respiration _____

GENERAL APPEARANCE:

PHYSICAL FINDINGS:

Handedness: ◯ Right ◯ Left ◯ Both

Inspection/Palpation:

Please comment on posture, tenderness/trigger points, spasm, crepitus, etc.

Cervical Spine Active Range of Motion (ROM): (N = Normal)

		Describe any pain with movement:
Flexion (N=60 degrees)	_____ degrees	_____
Extension (N=60 degrees)	_____ degrees	_____
Right lateral flexion (N=45 degrees)	_____ degrees	_____
Left lateral flexion (N=45 degrees)	_____ degrees	_____
Right rotation (N=70 degrees)	_____ degrees	_____
Left rotation (N=70 degrees)	_____ degrees	_____

Family name:	Given name:	File No.:

Ankylosed Joints:

Is the neck ankylosed? ◯ Yes ◯ No
If yes, describe and/or indicate position in degrees:

Associated Neurological Upper Extremity Findings:

Are there associated neurological upper extremity findings? ◯ Yes ◯ No
If yes, please complete applicable sections below:

Sensory Impairment:

Is there any related sensory impairment? ◯ Yes ◯ No

If yes, describe:

Motor Impairment:

Is there any related motor impairment? ◯ Yes ◯ No

If yes, describe using the following Strength Testing Scale.

Strength Testing: Grade using scale.

5 = Normal power
4 = Incomplete movement against resistance
3 = Movement against gravity
2 = Movement with gravity limited
1 = Flicker of contraction
0 = Total paralysis

Describe any atrophy present:

Reflexes: Grade using scale.

0 = Absent
1 = Diminished
2 = Normal
3 = Increased
4 = Clonus

	Right	Left
Biceps	_____	_____
Triceps	_____	_____
Brachioradialis	_____	_____
Patellar (knee)	_____	_____
Achilles (ankle)	_____	_____
Babinski	_____	_____

Fracture Status: (if applicable)

Please indicate the site and type of fracture(s):

Is the fracture well healed? ◯ Yes ◯ No
If no, please describe:

Comments:

Osteomyelitis: (if applicable)

Has the client had osteomyelitis? ◯ Yes ◯ No

If yes, please comment on sites, activity, dates and outcomes:

IF ADLs ARE AFFECTED ON A CONTINUOUS BASIS, DESPITE OPTIMAL TREATMENT, PLEASE COMPLETE THE ADL SECTION.

OTHER PERTINENT FINDINGS: (i.e. other conditions that may be contributing to the client's impairment)

Physician's signature:	Is VAC to be invoiced? ◯ Yes ◯ No	Telephone No. ( )	Today's date:

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Activities of Daily Living (ADL) Questionnaire

Family name:	Given name:	Date of Birth:
Name of Physician:		Date of Examination:

IF APPLICABLE TO THE CLAIMED/PENSIONED CONDITION(S), PLEASE COMPLETE THIS SHEET

Activities of Daily Living:

Please describe the impact that the <u>pensioned conditions</u> have on Activities of Daily Living.

Select the description that <u>most accurately</u> reflects the client's current level of functioning for each of the following activities:

Activity	Independent	Independent (with aids)	Requires reminders, prompting and/or supervision in addition to minor assistance	Needs extensive assistance	Totally dependent
Eating	◯	◯	◯	◯	◯
Bathing	◯	◯	◯	◯	◯
Grooming	◯	◯	◯	◯	◯
Dressing	◯	◯	◯	◯	◯
Toiletting	◯	◯	◯	◯	◯
Transferring	◯	◯	◯	◯	◯

Please elaborate (list aids required, ability to sit/stand unaided during task, safety concerns, bed mobility, etc.):

Continence/Incontinence:

Select the description that <u>most accurately</u> reflects the client's current level of bladder and bowel control:

	Continent (No assistance needed)	Occassional nighttime incontinence (once a week or less)	Daytime incontinence (more than once per week)	Daytime (daily) incontinence (requiring protective padding)	Daytime (daily) incontinence (requiring intervention by others)	Total incontinence
Bladder	◯	◯	◯	◯	◯	◯
Bowel	◯	◯	◯	◯	◯	◯

Comment: Please note the number of incontinence pads used/day, if applicable.

Locomotion: Please comment on any difficulty with walking, provide walking distance, and list aids required.

Chronic Pain: Please comment on pain intensity, frequency, symptoms and response to treatment.

Comments: Please remember to note other contributing conditions.

Physician's signature:	Today's date:

Family name:	Given name:	File No.:

Additional Comments:

Physician's signature:	Today's date: