Anciens Combattants Canada | Veterans Affairs Canada

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

Medical Questionnaire: Musculoskeletal Lower Limb 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: ◯ confirmed or ◯ provisional?

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.

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

Lower Extremity Function:

*Please complete this section **if** the client has a condition that affects the lower limb as a whole (e.g. spinal cord injury or disease which affects one or both lower limbs, complex regional pain syndromes Type 1 and Type 2 of the lower limb(s), compartment syndromes of the lower limb(s), peripheral neurological conditions of the lower limb(s)).*

Does the lower limb condition affect the client's ability to use the lower limb efficiently for walking, standing, etc? ◯ Yes ◯ No

If yes, please describe:

Walking/Mobility

Does the lower limb condition affect the client's ability to walk in a manner normal for age, on a variety of different terrains and at varying speeds? ◯ Yes ◯ No
If yes, describe:

Does one or both legs give way resulting in falls? ◯ Yes ◯ No
If yes, to what extent? Describe:

Is paresthesia and/or numbness present in one or both legs? ◯ Yes ◯ No
If yes, please describe:

Family name:	Given name:	File No.:

Stairs/Ramp Use:

What best describes the client's ability to manage (ascend and descend) stairs/ramps?

◯ Independent ◯ Requires use of hand rail(s) ◯ Requires personal assistance ◯ Unable to manage

Distance:

How far is the client able to walk without stopping, as a result of the claimed/pensioned condition?

◯ 100 meters or less ◯ 250 meters or less ◯ 500 meters or less ◯ greater than 500 meters

What is the limiting factor? Describe:

Is the client able to walk further after resting? ◯ Yes ◯ No

Aids/Assistance:

Does the client require personal assistance when walking as a result of the claimed/pensioned condition? ◯ Yes ◯ No

Does the client require a mobility aid when walking as a result of the claimed/pensioned condition? ◯ Yes ◯ No

If yes, a) identify the mobility aid(s) used (brace, cane, walker, etc).
b) under what conditions does the client use the aid/personal assistance?
c) how often is the aid/personal assistance required?

Does the client require a wheelchair? ◯ Yes ◯ No
If yes, please provide details and circumstances of use:

Family name:	Given name:	File No.:

HIP CONDITION(S):

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

Hip injury(ies): ◯ Yes ◯ No
If yes, please describe and include dates:

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

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:

Fracture Status: (if applicable)

Please indicate the site and type of fracture(s):
1.
2.
3.

Is/are the above noted fracture(s) well healed?
1. ◯ Yes ◯ No
2. ◯ Yes ◯ No
3. ◯ Yes ◯ No

If no, please describe noting non-union, malunion, angulation and displacement.

Osteomyelitis: (if applicable)

Has the client had osteomyelitis? ◯ Yes ◯ No

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

PLEASE FILL OUT PHYSICAL EXAMINATION SECTION ON PAGES 8 AND 9

Family name:	Given name:	File No.:

KNEE CONDITION(S):

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

Knee injury(ies): ◯ Yes ◯ No

If yes, please describe and include dates:

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No

If yes, indicate for which condition and indicate the nature of the test/consultation, and the appointment date (if known).

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:

Fracture Status: (if applicable)

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

1.
2.
3.

Is/are the above noted fracture(s) well healed?

1. ◯ Yes ◯ No
2. ◯ Yes ◯ No
3. ◯ Yes ◯ No

If no, please describe noting non-union, malunion, angulation and displacement.

Osteomyelitis: (if applicable)

Has the client had osteomyelitis? ◯ Yes ◯ No

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

PLEASE FILL OUT PHYSICAL EXAMINATION SECTION ON PAGES 8 AND 9

Family name:	Given name:	File No.:

ANKLE CONDITION(S):

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

Ankle injury(ies): ◯ Yes ◯ No
If yes, please describe and include dates:

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

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:

Fracture Status: (if applicable)

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

1.
2.
3.

Is/are the above noted fracture(s) well healed?

1. ◯ Yes ◯ No
2. ◯ Yes ◯ No
3. ◯ Yes ◯ No

If no, please describe noting non-union, malunion, angulation and displacement.

Osteomyelitis: (if applicable)

Has the client had osteomyelitis? ◯ Yes ◯ No

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

PLEASE FILL OUT PHYSICAL EXAMINATION SECTION ON PAGES 8 AND 9

Family name:	Given name:	File No.:

FOOT/TOES CONDITION(S):

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

Foot/Toe injury(ies): ◯Yes ◯ No

If yes, please describe and include dates:

Are further diagnostic tests or consultations ongoing/planned? ◯Yes ◯ No

If yes, indicate for which condition and indicate the nature of the test/consultation, and the appointment date (if known).

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:

Fracture Status: (if applicable)

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

1.

2.

3.

Is/are the above noted fracture(s) well healed?

1. ◯ Yes ◯ No
2. ◯ Yes ◯ No
3. ◯ Yes ◯ No

If no, please describe noting non-union, malunion, angulation and displacement.

Osteomyelitis: (if applicable)

Has the client had osteomyelitis? ◯Yes ◯ No

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

PLEASE FILL OUT PHYSICAL EXAMINATION SECTION ON PAGES 8 AND 9

Family name:	Given name:	File No.:

AMPUTATION(S):

MEDICAL HISTORY: Describe current relevant symptoms noting frequency, duration, aggravating and relieving factors. Indicate the site of the amputation(s). Please be as specific as possible (e.g. above knee amputation). Indicate length of stump in centimeters.

Is/are there relevant injury(ies)? ◯ ◯

If yes, please describe and include dates:

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No

If yes, indicate for which condition and indicate the nature of the test/consultation, and the appointment date (if known).

TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response), details of relevant surgery/hospitalization and other therapies (e.g. physiotherapy). Indicate if a prosthesis is used and if so, describe type.

COMPLICATIONS:

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

If yes, please provide details:

PLEASE FILL OUT PHYSICAL EXAMINATION SECTION ON PAGES 8 AND 9

Family name:	Given name:	File No.:

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

Height ________ Weight ________ Blood Pressure ________ Pulse ________ Respiration ________

GENERAL APPEARANCE:

Please provide the following information where and if applicable for each pensioned/claimed condition:

ACTIVE Range Of Motion (ROM): (N = Normal)

HIP	**Right**	**Left**	**Describe any pain with movement:**
Flexion (N = 120°)	______ degrees	______ degrees	______
Extension (N = 30°)	______ degrees	______ degrees	______
Abduction (N = 40°)	______ degrees	______ degrees	______
Adduction (N = 20°)	______ degrees	______ degrees	______
External Rotation (N = 45°)	______ degrees	______ degrees	______
Internal Rotation (N = 30°)	______ degrees	______ degrees	______

KNEE			
Flexion (N = 130°)	______ degrees	______ degrees	______
Extension (N = 0°)	______ degrees	______ degrees	______
Varus (N = nil)	______ degrees	______ degrees	______
Valgus (N = Nil)	______ degrees	______ degrees	______

Knee Stability	**Right**	**Left**	**Comments:**
Valgus stress	______	______	______
Varus stress	______	______	______
Drawer test (Anterior/Posterior)	______	______	______
Lachman (at 30 degrees)	______	______	______

ANKLE			
Dorsiflexion (N = 25°)	______ degrees	______ degrees	______
Inversion (N = 30°)	______ degrees	______ degrees	______
Plantar Flexion (N = 40°)	______ degrees	______ degrees	______
Eversion (N = 20°)	______ degrees	______ degrees	______

FOOT/TOES

Describe any loss of ROM of the toe(s). Identify the affected joint and provide a measurement of active ROM in degrees for all planes of movement.

Family name:	Given name:	File No.:

Ankylosed or Flail Joints:

If a joint(s) is/are ankylosed or flail, please indicate below:

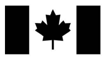
a) Joint affected: __________ ☐ ankylosed ________ position in degrees ☐ flail
b) Joint affected: __________ ☐ ankylosed ________ position in degrees ☐ flail
c) Joint affected: __________ ☐ ankylosed ________ position in degrees ☐ flail

OTHER EXAMINATION FINDINGS: Describe any relevant examination findings.

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)
If there are other conditions contributing to the impairment, describe and indicate to what degree:

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 pensioned conditions have on Activities of Daily Living.

Select the description that most accurately 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 most accurately 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: