Veterans Affairs Canada | Anciens Combattants Canada

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

Medical Questionnaire: Neurological 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.

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

Injuries? ◯ Yes ◯ No **Describe (include dates)**

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

Cognitive Function: ☐ **Normal**, skip to next section.

Cognitive Function:

If cognitive impairment is present, comment on the following areas: memory, judgement, work performance and orientation to person, place and time.

*** If psychometric testing/assessment has been performed, please provide this report.**

Emotion and Behaviour:

If emotional and/or behavioural impairment is present, comment on the following areas: any anxiety/depressive symptoms, resistive to care, suspiciousness, wandering (frequency), delusions and any inappropriate sexual or social behaviour:

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Personal Care:

If personal care impairment is present, comment on the following areas: the requirement for prompting/assistance with grooming, dressing or toileting, level of supervision required and level of bowel and bladder control.

Speech and Expression: ☐ **Normal**, skip to next section.

Speech:

If speech and expression impairment is present, comment on the following areas: speech sustainability, continuity and content, intelligibility, intensity and audibility.

Conversation:

Please comment on the client's ability to converse (initiating and maintaining conversation), word retrieval difficulties and ability to explain complex ideas.

Ability to write:

Does the client have dysgraphia? ◯ Yes ◯ No

If yes, which statement best describes his/her ability to write and use proper grammar/spelling?

◯ Unable to write more than short sentences which include frequent spelling errors.

◯ Able to write only some recognizable words.

◯ No functional writing ability other than practised sequences such as own name.

Comprehension: ☐ **Normal,** skip to next section.

If comprehension impairment is present select the descriptions, if any, which describe the client's ability to understand speech and writing:

☐ Understands movies, radio programs or group discussions with some difficulty.

☐ Is unable to cope with rapid change in topic or with complex topics.

☐ Can understand and follow simple conversation with cues or repetition.

☐ Alexia (inability to understand written language). ◯ Yes ◯ No
If yes, please describe:

☐ Understanding of slowly spoken simple sentences, frequent repetition is needed.

☐ Unable to understand simple instructions.

Cranial Nerve Condition: ☐ **Normal,** skip to next section.

Please identify which cranial nerve(s) is (are) affected.

For each impaired nerve, note if the condition is unilateral or bilateral and indicate the side. For those impairments which include hearing or visual loss, please complete the appropriate questionnaire. Note the physical findings of the impairment including motor and sensory losses. In cases of trauma, please indicate the anatomical site of the injury.

Family name:	Given name:	File No.:

Peripheral Nerve Condition: ☐ **Normal,** skip to next section.
Please identify which peripheral nerve(s) is (are) affected.

For each impaired nerve note if the condition is unilateral or bilateral and indicate the side. Note the physical findings of the impairment including motor and sensory losses. In cases of trauma, please indicate the anatomical site of the injury.

Upper Extremity Function:

*Please complete this section **if** the client has a neurological condition that affects the function(s) of the upper limb.*

Does the upper limb condition affect the client's ability to use the upper limb efficiently for feeding, dressing, writing and other daily tasks? ◯ Yes ◯ No
If yes, please describe:

Aids:
Does the client require aid(s) for performance of daily activities? ◯ Yes ◯ No
If yes, please describe:

Dexterity/Coordination:
Does the upper limb condition affect the client's dexterity/coordination? ◯ Yes ◯ No
If yes, what dexterity/coordination changes does the client experience? (check all which apply)

☐ Handwriting changes
☐ Difficulty manipulating small/fine objects (e.g. tying shoe laces, setting a watch)
☐ Difficulty manipulating larger objects (e.g. turning door handles)
☐ Other, please specify:

Grip Strength:
Does the upper limb condition affect the client's grip strength? ◯ Yes ◯ No
If yes, what objects does the client have difficulty gripping?

Pain and Fatigue:
Does the upper limb condition cause excessive pain and/or fatigue with use? ◯ Yes ◯ No
If yes, describe when the excessive pain and fatigue occurs:
◯ within 10 minutes ◯ within 1 hour ◯ toward the end of the day ◯ other ____________________

Intractable Pain:
Does the client have intractable pain? ◯ Yes ◯ No
If yes, please describe the pain and treatment modalities:

Paresthesia:
Are paresthesias present in the upper limbs? ◯ Yes ◯ No
If yes, select: ◯ Right ◯ Left ◯ Both
Please describe:

Family name:	Given name:	File No.:

Lower Extremity Function:

*Please complete this section **if** the client has a neurological condition that affects the lower limb.*

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:

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

Does the client require personal assistance 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:

Intractable Pain:

Does the client have intractable pain? ◯ Yes ◯ No

If yes, please describe the pain and treatment modalities:

Paresthesia:

Are paresthesias present in the lower limbs? ◯ Yes ◯ No

If yes, select: ◯ Right ◯ Left ◯ Both

Please describe:

Family name:	Given name:	File No.:

Seizure Conditions: ☐ **Normal,** skip to next section.

History of Seizure Activity:
For VAC pension purposes,

- **Major seizures** are those characterized by generalized tonic-clonic convulsion with unconsciousness.
- **Minor seizures** are those characterized by a brief interruption in consciousness or conscious control associated with staring, rhythmic eye blinking, or head nodding, or sudden jerking movements of the limbs and/or head, or sudden loss of postural control.

Has the client had any seizures in the past 5 years? ○ Yes ○ No
If yes, on average - how many major seizures did the client have over the past 12 months? ____________

on average - how many minor seizures has the client had over the past 12 months? ____________

on average - how many minor seizures has the client had per week over the past 12 months? ____________

Anti-convulsant Medications:
Does the client require regular anti-convulsant medications? ○ Yes ○ No

Supervision:
Does the client require supervision as a result of the seizure disorder? ○ Yes ○ No
If yes, please select:

○ intermittently, only for certain activities? Please list: ____________

○ constantly?

Does the client require protective equipment for safety? ○ Yes ○ No
If yes, please elaborate.

Narcolepsy and Cataplexy: ☐ **Normal,** skip to next section.

Does the client have narcoleptic attacks? ○ Yes ○ No

Does he/she require medication for narcolepsy? ○ Yes ○ No
If yes, please select: ○ intermittent ○ continuous

Does the client have cataplectic attacks? ○ Yes ○ No
Does he/she require medication for cataplexy? ○ Yes ○ No
If yes, please select: ○ intermittent ○ continuous
Do the narcoleptic attacks and/or cataplectic attacks impact on safety of self or others, despite medication? ○ Yes ○ No
Please describe:

Headache Conditions: ☐ **Normal,** skip to next section.
Frequency of Headache:
How many days of the year does the client experience headaches?
○ less than 30 days per year
○ 30 to 100 days per year
○ more than 100 days per year

Do headaches occur on a weekly basis? ○ Yes ○ No
If yes, do the headaches last for at least two consecutive days on a weekly basis? ○ Yes ○ No

Does the client require bed rest? ○ Yes ○ No
If yes, how often?

○ occasionally

○ most of the time

○ all of the time

Family name:	Given name:	File No.:

Other Impairment - Miscellaneous Neurological: ☐ **Normal,** skip to next section.

Please select the statement that provides the most appropriate descriptor of the client's neurological impairment:

- ☐ recurrent transient ischemic attacks
- ☐ cerebral aneurysms not surgically repaired
- ☐ facial tics (e.g. hemifacial spasms)

Does the client have trigeminal neuralgia (tic douloureux)? ◯ Yes ◯ No
If yes, please select the frequency:

◯ intermittent ◯ on most days

Intractable Pain:
Does the client have intractable pain? ◯ Yes ◯ No
If yes, please describe the pain and treatment modalities:

Does the client have dysphagia from a neurological condition? ◯ Yes ◯ No
If yes, select the most appropriate description:

- ☐ Requires avoidance of certain foods.
- ☐ Choking on liquids or semi-solid foods on a frequent basis.
- ☐ Nasal regurgitation or aspiration on a frequent basis.
- ☐ Inability to handle oral secretions without choking, requiring assistance and suctioning.

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

TREATMENT: Provide a complete medication list (indicating dosage, frequency, duration, route and response) and 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:

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:

Handedness: ◯ Right ◯ Left ◯ Both

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: