Veterans Affairs Canada | Anciens Combattants Canada

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# Medical Questionnaire: Musculoskeletal Thoracolumbar Spine, Pelvic and Sacroiliac Joint 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.**

Does the client suffer radicular/sciatic pain as a result of his thoracolumbar spine condition? ◯ Yes ◯ No
If yes, indicate site and frequency:

Back injury(ies)? ◯ Yes ◯ No **Describe (include dates):**

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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)**

**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:**

**Inspection/Palpation:**
Please comment on posture, tenderness/trigger points, spasm, etc.

**Leg Length:** (measured from anterior superior iliac spine to inferior tip of medial malleolus): Right leg: _____ centimeters
Left leg: _____ centimeters

**Gait:** Describe gait:

**Thoracolumbar Spine Active Range Of Motion (ROM):** (N = normal)

| | | | Describe any pain with movement: |
|---|---|---|---|
| Flexion (N=90 degrees) | _____ | degrees | _____ |
| Extension (N=30 degrees) | _____ | degrees | _____ |
| Right lateral flexion (N=35 degrees) | _____ | degrees | _____ |
| Left lateral flexion (N=35 degrees) | _____ | degrees | _____ |
| Right rotation (N=35 degrees) | _____ | degrees | _____ |
| Left rotation (N=35 degrees) | _____ | degrees | _____ |

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**Ankylosed Joints:**

Is there ankylosis present in the lumbar spine? ◯ Yes ◯ No
If yes, describe and/or indicate position in degrees:

**Associated Neurological Lower Extremity Findings:**

Are there associated neurological findings in the lower extremity(ies)? ◯ Yes ◯ No
If yes, please complete applicable sections below:

**Sensory Impairment:**
Is there any related sensory impairment? ◯ Yes ◯ No
If yes, describe and indicate site:

**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

If atrophy is present, provide bilateral measurements:

**Reflexes:** Grade using scale.

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

| | Right | Left |
|---|---|---|
| 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.: |
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**Additional Comments:**

| Physician's signature: | Today's date: |
|---|---|