STATION 3: Reviewing the Rating

Clint Barton calls your office and begins thanking you for all your help with his claim. He just received some money into his account and is now able to pay his bills after losing his job last month.

Using the provided Claim forms, evidence, C&P Exams, Codesheet and Narrative review Mr. Barton's Rating decision for any errors made by VA.

When reviewing a rating decision, be sure to review the entire file including:

- Effective dates
- Rating Percentages
- Any additional benefits that should have been awarded

Please note that because the VSO in the scenario failed to ask the veteran about dependents on their initial meeting, the 21-686C was not submitted with the original claim and dependents were not captured on this rating.

Once you finish your review, complete the chart and answer the following questions:

Rated Condition	Issues (if correct, write none)
Unspecified Anxiety Disorder	
Lumbosacral Strain	
Migraine Headaches	
Erectile Dysfunction	
Left Shoulder Strain	
Deviated Septum	
Right Shoulder Strain	

VETERANS OF FOREIGN WARS.

1. Are there any additional issues you found in the rating decision that need to be corrected? If so, list them here.

   _____
   _____
   _____
   _____

2. What type of appeal would you pursue to correct this rating?

   _____
   _____
   _____
   _____

1. Would you recommend any other follow up claim action to the veteran after their appeal?

   _____
   _____
   _____
   _____

Rating Decision	**Regional Office** VA Regional Office			Page 1 of 1 04/07/2020
Name of Veteran **Clint Barton**	VA FILE NUMBER 011 25 2006	SSN 011 25 2006	POA **VFW**	COPY TO VFW

ACTIVE DUTY			
EOD	**RAD**	**BRANCH**	**CHARACTER OF DISCHARGE**
06/01/1995	06/01/2018	Army	Honorable

LEGACY CODES			
ADD'L SVC CODE	**COMBAT CODE**	**SPECIAL PROV CDE**	**FUTURE EXAM DATE**
	1		

JURISDICTION: Original Disability Claim 06/03/2022

ASSOCIATED CLAIM(s): 010; Initial; 06/03/2022

SUBJECT TO COMPENSATION (1.SC)

9435 UNSPECIFIED ANXIETY DISORDER
Service Connected, Gulf War, Incurred
Static Disability
50% from 06/03/2022

5237 LUMBOSACRAL STRAIN
Service Connected, Gulf War, Incurred
Static Disability
20% from 06/03/2022

8100 MIGRAINE HEADACHES
Service Connected, Gulf War, Incurred
Static Disability
0% from 06/03/2022

7522 ERECTILE DYSFUNCTION
Service Connected, Peacetime, Incurred
Static Disability
0% from 06/03/2022

5201 LEFT SHOULDER STRAIN
Service Connected, Gulf War, Incurred
Static Disability
0% from 06/03/2022

Clint Barton
011-25-2006

NOT SUBJECT TO COMPENSATION

6502	DEVIATED SEPTUM Not Service Connected, Gulf War, Not Incurred/Caused by service Original Date of Denial 06/03/2022

COMBINED EVALUATION FOR COMPENSATION:

60% from 06/03/2022

_____
RVSR

DEPARTMENT OF VETERANS AFFAIRS
VA Regional Office
Street Address
City, ST 12345

Clint Barton

VA File Number
011 25 2006

Represented by:
Veterans of Foreign Wars

Rating Decision
September 16, 2022

INTRODUCTION

The records reflect that you are a veteran of the Gulf War Era. You served in the Army from June 1, 1995 to June 1, 2018. You filed an original disability claim that was received on June 3, 2022. We have assigned an effective date of June 3, 2022, which is the day the claim was received. It is the earliest date allowable by law and will be the same for all disorders found to be service connected by this rating decision. Based on a review of the evidence listed below, we have made the following decision(s) on your claim.

DECISION

1. Service connection for Unspecified Anxiety Disorder is granted with an elevation of 50 percent effective June 3, 2022.

2. Service connection for Lumbosacral Strain is granted with an evaluation of 20 percent effective June 3, 2022.

3. Service connection for Migraine headaches is granted with an evaluation of 0 percent effective June 3, 2022.

4. Service connection for Erectile dysfunction is granted with an evaluation of 0 percent effective June 3, 2022.

5. Service connection for Left Shoulder Strain is granted with an evaluation of 0 percent effective June 3, 2022

6. Service connection for Deviated Septum is denied.

7. We are paying you as a single veteran with no dependents.

EVIDENCE

- Service treatment records from June 1, 1995 to June 1, 2018.
- Your claim for compensation on VA Form 21-526EZ received June 3, 2022
- VA compensation and pension examination dated June 13, 2013
- Possible private medical records
- DD-214
- Lay statements from Stark
- Lay statement from Rodgers

REASONS FOR DECISION

1. Service connection for Unspecified Anxiety Disorder.

Service connection for Unspecified Anxiety Disorder has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

The effective date of this grant is June 3, 2022. Service connection has been established from the day after your discharge from active duty. When a claim of service connection is received within one year of discharge from active duty, the effective date is the day after discharge. (38 CFR 3.400)

An evaluation of 50 percent is assigned from June 3, 2022.

We have assigned a 50 percent evaluation for your Unspecified Anxiety Disorder based on:

• Anxiety
• Chronic sleep impairment
• Depressed mood
• Difficulty in adapting to a worklike setting
• Difficulty in adapting to stressful circumstances
• Difficulty in adapting to work
• Difficulty in establishing and maintaining effective work and social relationships
• Disturbances of motivation and mood
• Forgetting directions
• Forgetting names
• Forgetting recent events
• Mild memory loss
• Occupational and social impairment with reduced reliability and productivity
• Suicidal ideation

The overall evidentiary record shows that the severity of your disability most closely

approximates the criteria for a 50 percent disability evaluation. (38 CFR 4.7, 38 CFR 4.126)

A higher evaluation of 70 percent is not warranted for a mental disorder unless the evidence

shows total occupational and social impairment, due to such symptoms as:

• Gross impairment in thought processes or communication
• Persistent delusions or hallucinations
• Grossly inappropriate behavior
• Persistent danger of hurting self or others
• Intermittent inability to perform activities of daily living (including maintenance of minimal personal hygiene)
• Disorientation to time or place
• Memory loss for names of close relatives, own occupation, or own name. (38 CFR 4.125, 38 CFR 4.126, 38 CFR 4.130

2. Service connection Lumbosacral Strain

Service connection for lumbar strain has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)
The effective date of this grant is June 3, 2022.

An evaluation of 20 percent is assigned from June 3, 2022.

We have assigned a 20 percent evaluation for your lumbar strain based on:
• Combined range of motion of the thoracolumbar spine not greater than 120 degrees
• Forward flexion of the thoracolumbar spine greater than 30 degrees but not greater than 60 degrees

Additional symptom(s) include:
• Objective evidence of lack of endurance
• Painful motion

The provisions of 38 CFR §4.40 and §4.45 concerning functional loss due to pain, fatigue, weakness, or lack of endurance, incoordination, and flare-ups, as cited in DeLuca v. Brown and Mitchell v. Shinseki, have been considered and were applied based on additional joint limitation.

A higher evaluation of 40 percent is not warranted for diseases and injuries of the thoracolumbar spine unless the evidence shows:

• Favorable ankylosis of the entire thoracolumbar spine; or,
• Forward flexion of the thoracolumbar spine 30 degrees or less. (38 CFR 4.71a)

3. Service connection for Migraine Headaches

Service connection for Migraine Headaches has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304) A non-compensable evaluation is assigned from June 3, 2022.

We have assigned a non-compensable evaluation for your headache based on:
• A diagnosed disability with no compensable symptoms (38 CFR 4.31)

A higher evaluation of 10 percent is not warranted unless there are characteristic prostrating attacks averaging one in 2 months over last several months. (38 CFR 4.124a)

4. Service connection for Erectile Dysfunction

Service connection for Erectile Dysfunction has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304) A non-compensable evaluation is assigned from June 3, 2022.

We have assigned a noncompensable evaluation for your erectile dysfunction based on:
- Loss of erectile power

Note: In every instance where the schedule does not provide a zero percent evaluation for a diagnostic code, a zero percent evaluation shall be assigned when the requirements for a compensable evaluation are not met. {38 CFR §4.31}

A higher evaluation of 20 percent is not warranted unless there is deformity with loss of erectile power.

5. Service connection for Left Shoulder strain.

Service connection for Left shoulder Strain, right has been established as directly related to military service. (38 CFR 3.303, 38 CFR 3.304)

An evaluation of 0 percent is assigned from June 3, 2022.

We have assigned a 0 percent evaluation for your shoulder strain, left based on:

• A diagnosed condition without any compensable symptoms.

A higher evaluation of 20 percent is not warranted for limitation of motion of the arm unless the evidence shows:

• Painful motion of the shoulder
• Limited motion of the arm midway between side and shoulder level (flexion and/or abduction limited to 45 degrees). (38 CFR 4.69, 38 CFR 4.71a)

6. Service connection for Deviated Septum

Service connection may be granted for a disability which began in military service or was caused by some event or experience in service. While your service treatment records reflect complaints, treatment, or a diagnosis similar to that claimed, the medical evidence supports the conclusion that there is no evidence of a chronic disability subject to service connection as shown by evidence following service.

There was no continuity of symptoms from service to the present. Service connection for deviated septum is denied since this condition neither occurred in nor was caused by service.

Department of Veterans Affairs

INTERNAL VETERAN AFFAIRS USE
HEADACHES (INCLUDING MIGRAINE HEADACHES) DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY*** OR ***REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING THIS FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
Barton, Clint	011-25-20006

NOTE TO PHYSICIAN – Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

IS THIS QUESTIONNAIRE BEING COMPLETED IN CONJUNCTION WITH A VA 21-2507, C&P EXAMINATION REQUEST?

☒ Yes ☐ No

How was the examination completed (check all that apply)?

☐ In-person examination

☒ Records reviewed

☒ Examination via approved video telehealth

☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE) AND EVIDENCE REVIEW

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 questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

EVIDENCE REVIEWED *(check all that apply)*:

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

EVIDENCE COMMENTS:

SECTION I - DIAGNOSIS

DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A HEADACHE CONDITION?

☒ YES ☐ NO *(If "Yes," complete Item 1B)*

SELECT THE VETERAN'S CONDITION *(check all that apply)*:

☒ Migraine including migraine variants	ICD Code: G43	Date of Diagnosis: 12.13.2004
☒ Tension	ICD Code: G44.2	Date of Diagnosis: 12.13.2004
☐ Cluster	ICD Code:	Date of Diagnosis:
☐ Other *(specify type of headache)*:	ICD Code:	Date of Diagnosis:
Other Diagnosis #1	ICD Code:	Date of Diagnosis:
Other Diagnosis #2	ICD Code:	Date of Diagnosis:

IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO A HEADACHE CONDITION, LIST USING ABOVE FORMAT:

SECTION II – MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course) OF THE VETERAN'S HEADACHE CONDITIONS *(brief summary)*:

The claimant reports this condition started in 2004

The claimant reports current symptoms as throbbing, head pain with associated symptoms such as nausea, light and noise sensitivity.

The claimant reports treatment included:Amitriptyline

Current Symptoms: headaches with sensitivity to light and noise with nausea.

2B. DOES THE VETERAN'S TREATMENT PLAN INCLUDE TAKING MEDICATION FOR THE DIAGNOSED CONDITION?

☒ YES ☐ NO IF YES, DESCRIBE TREATMENT *(list only those medications used for the diagnosed condition)*:

Amitriptyline

SECTION III – SYMPTOMS

3A. DOES THE VETERAN EXPERIENCE HEADACHE PAIN?

☒ YES ☐ NO

(If "Yes," check all that apply to headache pain):

☒ Constant head pain
☒ Pulsating or throbbing head pain
☒ Pain localized to one side of the head
☒ Pain on both sides of the head
☐ Pain worsens with physical activity
☐ Other, describe:

3B. DOES THE VETERAN EXPERIENCE NON-HEADACHE SYMPTOMS ASSOCIATED WITH HEADACHES? *(Including symptoms associated with an aura prior to headache pain)*

☒ YES ☐ NO

(If "Yes," check all that apply):

☒ Nausea
☒ Vomiting
☒ Sensitivity to light
☒ Sensitivity to sound
☒ Changes in vision (*such as scotoma, flashes of light, tunnel vision)*
☒ Sensory changes *(such as feeling of pins and needles in extremities)*
☐ Other, describe:

SECTION III – SYMPTOMS

3C. INDICATE DURATION OF TYPICAL HEAD PAIN

- ☒ Less than 1 day
- ☐ 1-2 days
- ☐ More than 2 days
- ☐ Other, describe:

3D. INDICATE LOCATION OF TYPICAL HEAD PAIN

- ☒ Right side of head
- ☐ Left side of head
- ☐ Both sides of head
- ☐ Other, describe:

SECTION IV - PROSTRATING ATTACKS OF HEADACHE PAIN

4A. MIGRAINE / NON-MIGRAINE- DOES THE VETERAN HAVE CHARACTERISTIC PROSTRATING ATTACKS OF MIGRAINE / NON-MIGRAINE HEADACHE PAIN?

☐ YES ☒ NO

(If "Yes," indicate frequency, on average, of prostrating attacks over the last several months):

- ☐ With less frequent attacks
- ☐ Once in 2 months
- ☐ Once every month

4B. DOES THE VETERAN HAVE VERY PROSTRATING AND PROLONGED ATTACKS OF MIGRAINES/NON-MIGRAINE PAIN PRODUCTIVE OF SEVERE ECONOMIC INADAPTABILITY?

☐YES ☐NO

SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

5A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☐ YES ☒ NO

IF YES, DESCRIBE *(brief summary)*:

5B. 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.

5C. COMMENTS, IF ANY:

SECTION VI - DIAGNOSTIC TESTING

NOTE: Diagnostic testing is not required for this examination report; if studies have already been completed, provide the most recent results below.

ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☒ NO

IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS *(brief summary)*:

SECTION VII - FUNCTIONAL IMPACT

DOES THE VETERAN'S HEADACHE CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☒ YES ☐ NO *(If "Yes," describe impact of the veteran's headache condition, providing one or more examples)*:

Intermittent headaches with poor concentration, difficulty with finishing tasks.

SECTION VIII - REMARKS

8. REMARKS *(If any)*

For the claimant's claimed condition of traumatic headaches there is no diagnosis because there are no findings, signs and or symptoms to support a diagnosis. For the claimant's claimed condition of migraine please refer to the diagnosis section.

The suicide risk level is not at elevated acute risk.

SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

9A. PHYSICIAN'S SIGNATURE	9B. PHYSICIAN'S PRINTED NAME	9C. DATE SIGNED1
Sonya Dewey, APRN, FNP-C 20614102-11d2-4d47-b805-a66caa653d05	DEWEY SONYA FNP-C NURSE PRACTITIONER	8/11/2022 (UTC)

9D. PHYSICIAN'S PHONE NUMBER AND FAX NUMBER	9E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	9F. PHYSICIAN'S ADDRESS
2547680468 2542671077	NPI#:1275004855 Lic#:AP137634 TX	581 PAN AMERICAN DR SUITE 1 HARKER HEIGHTS TX 76548

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, 58VA21/22/28, 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 a 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.

Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
MALE REPRODUCTIVE ORGAN CONDITIONS (INCLUDING PROSTATE CANCER) DISABILITY BENEFITS QUESTIONNAIRE

Name of Claimant/Veteran:	Claimant/Veteran's Social Security Number:	Date of Examination:08-11-2022 T11:30:00
Barton,Clint	011-25-2006	

Note to examiner – The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

Is this questionnaire being completed in conjunction with a VA C&P examination request? ☒ Yes ☐ No

How was the examination completed? (check all that apply)

☒ In-person examination

☒ Records reviewed

☐ Examination via approved video telehealth

☐ Other, please specify in comments box

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

Indicate the 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 questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

Evidence Reviewed (check all that apply):

☐ Not requested
☐ VA claims file (hard copy paper C-file)
☒ VA e-folder
☐ VA electronic health record
☐ No records were reviewed
☐ Other, please identify other evidence reviewed.

Evidence Comments:

SECTION I - DIAGNOSIS

Note: These are condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. List the claimed condition(s) that pertain to this questionnaire:

erectile dysfunction

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

1B. Does the Veteran now have or has he ever been diagnosed with any conditions of the male reproductive system?

☒ Yes ☐ No If yes, complete Item 1C

SECTION I – DIAGNOSIS (Continued)

1C. Select diagnoses associated with the claimed condition(s). Check all that apply.

☒	Erectile dysfunction, with or without penile deformity	ICD code:	N52.9	Date of diagnosis:	12.13.2021
☐	Testis, atrophy, one or both	ICD code:		Date of diagnosis:	
☐	Testis, removal, one or both	ICD code:		Date of diagnosis:	
☐	Epididymitis, chronic	ICD code:		Date of diagnosis:	
☐	Orchitis (unilateral or bilateral), chronic only	ICD code:		Date of diagnosis:	
☐	Urethritis	ICD code:		Date of diagnosis:	
☐	Varicocele/Hydrocele	ICD code:		Date of diagnosis:	
☐	Prostatitis	ICD code:		Date of diagnosis:	
☐	Prostate gland injuries, infections, hypertrophy, postoperative residuals, bladder outlet obstruction				
	Specify specific diagnosis:				
		ICD code:		Date of diagnosis:	
☐	Neoplasms of the male reproductive system, including prostate cancer	ICD code:		Date of diagnosis:	
☐	Other male reproductive system condition *(specify diagnosis, providing only diagnoses that pertain to the male reproductive system)*				
	Other diagnosis #1:	ICD code:		Date of diagnosis:	
	Other diagnosis #2:	ICD code:		Date of diagnosis:	

1D. If there are any additional diagnoses that pertain to male reproductive organ conditions, list using above format:

SECTION II – MEDICAL HISTORY

2A. Describe the history, including onset and course, of the Veteran's male reproductive organ condition(s), including prostate cancer. Brief summary:

Condition began spontaneously with inability to maintain erection in 2013

Condition has stayed the same

Meds: Viagra

2B.Does the Veteran's treatment plan include taking continuous medication for the diagnosed condition?

☒ Yes ☐ No List medications taken for the male reproductive organ condition:

Viagra

2C. Has the Veteran had an orchiectomy?

☐ Yes ☒ No

Indicate testicle removed: ☐ Right ☐ Left ☐ Both

Indicate reason for removal:

☐ Undescended

☐ Congenitally underdeveloped

☐ Other, provide reason for removal:

SECTION II – MEDICAL HISTORY (Continued)

For VA purposes, renal dysfunction includes evidence demonstrating the following for at least 3 consecutive months, during the past 12 months: glomerular filtration rate (GFR) of less than 60 mL/min/1.73m2; or GFR from 60 to 89 mL/min/1.73m2 and the presence of at least one of the following: recurrent red blood cell (RBC) casts, white blood cell (WBC) casts, granular casts, structural kidney abnormalities (cystic, obstructive, or glomerular), or increased secretion of protein in the urine (proteinuria). GFR, estimated GFR (eGFR), and creatinine based approximations of GFR will be accepted for evaluation purposes when determined to be appropriate and calculated by a medical professional. Note: If the medical record contains multiple lab tests during this 12 month period, separated by at least 3 months, and there is no evidence to contradict those findings in the interim period, VA will accept that the demonstrated renal dysfunction has persisted for at least 3 consecutive months during the past 12 months.

2D.Is there any renal dysfunction due to any conditions listed in the diagnosis section?

☐ Yes ☒ No

If the Veteran has renal dysfunction, also complete the appropriate genitourinary questionnaire.

SECTION III – VOIDING DYSFUNCTION

3A. Does the Veteran have a voiding dysfunction?

☐ Yes ☒ No If yes, complete the remainder of section III.

3B. Etiology of voiding dysfunction:

3C. Does the voiding dysfunction cause urine leakage?

☐ Yes ☐ No

Indicate severity. Check one:

☐ Does not require the wearing of absorbent material

☐ Requires absorbent material which must be changed less than 2 times per day

☐ Requires absorbent material which must be changed 2 to 4 times per day

☐ Requires absorbent material which must be changed more than 4 times per day

☐ Other, describe:

3D. Does the voiding dysfunction require the use of an appliance?

☐ Yes ☐ No

If yes, describe the appliance:

3E. Does the voiding dysfunction cause increased urinary frequency?

☐ Yes ☐ No

If yes, check all that apply:

☐ Daytime voiding interval between 2 and 3 hours

☐ Daytime voiding interval between 1 and 2 hours

☐ Daytime voiding interval less than 1 hour

☐ Nighttime awakening to void 2 times

☐ Nighttime awakening to void 3 to 4 times

☐ Nighttime awakening to void 5 or more times

3F. Does the voiding dysfunction cause signs or symptoms of obstructed voiding?

☐ Yes ☐ No

If yes, check all that apply.

☐ Hesitancy

☐ Slow stream

☐ Weak stream

☐ Decreased force of stream

☐ Obstructive symptomatology without stricture disease requiring dilatation 1 to 2 times per year

☐ Stricture disease requiring dilatation 1 to 2 times per year

☐ Stricture disease requiring periodic dilatation every 2 to 3 months

☐ Recurrent urinary tract infections secondary to obstruction

☐ Uroflowmetry peak flow rate less than 10 cc/sec

☐ Post void residuals greater than 150 cc

☐ Urinary retention requiring intermittent catheterization

☐ Urinary retention requiring continuous catheterization

☐ Other, describe

SECTION IV – ERECTILE DYSFUNCTION

4A. Does the Veteran have erectile dysfunction?

☒ Yes ☐ No

If yes, provide etiology, if known.

☒ Etiology unknown

SECTION V – RETROGRADE EJACULATION

5A. Does the Veteran have retrograde ejaculation?

☐ Yes ☒ No

If yes, provide etiology, if known.

☐ Etiology unknown

SECTION VI – MALE REPRODUCTIVE ORGAN INFECTIONS, INCLUDING URINARY TRACT INFECTIONS

6A. Does the Veteran have a history of chronic prostatitis, urethritis, epididymitis, orchitis, or urinary tract infections?

☐ Yes ☒ No

If yes, indicate all treatment modalities used for chronic prostatitis, urethritis, epididymitis, orchitis, or urinary infections. Check all that apply.

☐ No treatment

☐ Recurrent symptomatic infection requiring drainage by stent or nephrostomy tube

If checked, indicate dates drainage was performed over the past 12 months:

☐ Recurrent symptomatic infection requiring hospitalization

If checked, indicate frequency of hospitalizations: ☐ 1 or 2 per year ☐ Greater than 2 times per year

☐ Recurrent symptomatic infection requiring continuous intensive management

If checked, indicate types of treatment and medications used over the past 12 months:

☐ Recurrent symptomatic infection requiring suppressive drug therapy

☐ For less than 6 months ☐ Lasting 6 months or longer

If checked, list medications used and indicate dates for courses of treatment over the past 12 months:

☐ Other, describe

SECTION VII – PHYSICAL EXAM

7A. Penis

☐ Normal

☐ Not examined per Veteran's request

☒ Not examined per Veteran's request; Veteran reports normal anatomy with no penile deformity or abnormality

☐ Not examined; penis exam not relevant to condition

☐ Abnormal If checked, indicate the abnormality(ies)

- ☐ Loss/removal of less than half
- ☐ Loss/removal of half or more
- ☐ Loss/removal of glans
- ☐ Penis deformity

If checked, describe:

SECTION VII – PHYSICAL EXAM (Continued)

7B. Testes

☐ Normal Indicate side ☐ Right ☐ Left ☐ Both

☐ Not examined per Veteran's request

☒ Not examined per Veteran's request; Veteran reports normal anatomy with no testicular deformity or abnormality

☐ Not examined; testicular exam not relevant to condition

☐ Abnormal

If abnormal, check all that apply:

Right testicle

- ☐ Complete atrophy of
- ☐ Size 1/3 or less of normal
- ☐ Size 1/2 or less, but more than 1/3 of normal
- ☐ Considerably harder than the contralateral (corresponding) normal testicle
- ☐ Considerably softer than the contralateral (corresponding) normal testicle
- ☐ Absent
- ☐ Other abnormality

Describe

Left testicle

- ☐ Complete atrophy of
- ☐ Size 1/3 or less of normal
- ☐ Size 1/2 or less, but more than 1/3 of normal
- ☐ Considerably harder than the contralateral (corresponding) normal testicle
- ☐ Considerably softer than the contralateral (corresponding) normal testicle
- ☐ Absent
- ☐ Other abnormality

Describe

7C. Epididymis

☐ Normal Indicate side ☐ Right ☐ Left ☐ Both

☐ Not examined per Veteran's request

☒ Not examined per Veteran's request; Veteran reports normal anatomy of epididymis with no deformity or abnormality

☐ Not examined; epididymis exam not relevant to condition

☐ Abnormal

If abnormal, check all that apply:

Right epididymis

- ☐ Tender to palpation
- ☐ Other, describe

Left epididymis

- ☐ Tender to palpation
- ☐ Other, describe

7D. Prostate

☐ Normal

☐ Not examined per Veteran's request

☒ Not examined; prostate exam not relevant to condition

☐ Abnormal

If abnormal, describe.

SECTION VIII – TUMORS AND NEOPLASMS

8A. Does the Veteran currently have, or has had, a benign or malignant neoplasm or metastases related to any condition in the diagnosis section?

☐ Yes ☒ No

If yes, complete the remainder of section VIII.

8B. Is the neoplasm

☐ Benign

☐ Malignant (If malignant complete the following):

☐ Active ☐ In remission

☐ Primary ☐ Secondary (metastatic) If secondary, indicate the primary site, if known.

8C. Has the Veteran completed treatment or is the Veteran currently undergoing treatment for a benign or malignant neoplasm or metastases?

☐ Yes ☐ No; watchful waiting

If yes, indicate type of treatment the Veteran is currently undergoing or has completed. Check all that apply:

☐ Treatment completed

☐ Surgery

If checked, describe:

Date(s) of surgery:

☐ Prostatectomy

☐ Radical prostatectomy Date of surgery:

☐ Transurethral resection prostatectomy Date of surgery:

☐ Other, describe: Date of surgery:

☐ Radiation therapy Date of completion of treatment or anticipated date of completion:

☐ Antineoplastic chemotherapy Date of completion of treatment or anticipated date of completion:

☐ Brachytherapy Date of completion of treatment or anticipated date of completion:

☐ Androgen deprivation therapy (hormonal therapy): Date of completion of treatment or anticipated date of completion:

☐ Other therapeutic procedure and/or treatment. Describe:

Date of procedure, if applicable:

Date of completion of treatment or anticipated date of completion, if applicable:

8D. Does the Veteran currently have any residuals or complications due to the neoplasm (including metastases) or its treatment, other than those already documented in the report above?

☐ Yes ☐ No

If yes, list residuals or complications (brief summary), and also complete the appropriate questionnaire.

8E. If there are additional benign or malignant neoplasms or metastases related to any of the diagnoses in the diagnosis section, describe using the above format.

SECTION IX – OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS AND SCARS

9A. 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:

9B. Does the Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis section?

☐ Yes ☒ No If yes, also complete the appropriate dermatological questionnaire

SECTION X – DIAGNOSTIC TESTING

NOTE: If imaging studies, diagnostic procedures or laboratory testing have been performed and reflects the Veteran's current condition, provide most recent results; no further studies or testing are required for this examination.

10A. Has a biopsy been performed?

☐ Yes ☒ No

Date of biopsy:

Results:

10B. Are there any other significant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es) that were reviewed in conjunction with this examination?

☐ Yes ☒ No If yes, provide type of test or procedure, date and results. Brief summary:

SECTION XI – FUNCTIONAL IMPACT

Note: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

11A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?

☐ Yes ☒ No

If yes, describe the functional impact of each condition, providing one or more examples:

SECTION XII - REMARKS

12A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

The rectal exam was not performed as it is not relevant to the claimed condition.

Claimant reports normal anatomy with no penile deformity or abnormality. Claimant reports normal anatomy with no testicular deformity or abnormality. Claimant reports normal anatomy with no epididymis deformity or abnormality. The prostate exam was not performed as it is not relevant to the claimed condition.

For the claimant's claimed condition of erectile dysfunction please refer to the diagnosis section.

The suicide risk level is not at elevated acute risk.

Section VI:

There is no history of epididymitis, epididymo-orchitis or prostatitis. Section VI:

There is no history of recurrent symptomatic urinary tract or kidney infections.

SECTION XIII – EXAMINER'S CERTIFICATION AND SIGNATURE

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

13A. Examiner's signature	13B. Examiner's printed name	13C. Date signed
Sonya Dewey, APRN, FNP-C 20614102-11d2-4d47-b805-a66caa653d05	DEWEY SONYA FNP-C NURSE PRACTITIONER	8/11/2022 (UTC)

13D. Examiner's phone/fax numbers	13E. National Provider Identifier (NPI) number	13F. Medical license number and state
2547680468 2542671077	1275004855	AP137634 TX

13G. Examiner's address
581 PAN AMERICAN DR SUITE 1 HARKER HEIGHTS TX 76548

Department of Veterans Affairs

MENTAL DISORDERS (OTHER THAN PTSD AND EATING DISORDERS) DISABILITY BENEFITS QUESTIONNAIRE

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
Clint Barton	011-25-2006

IMPORTANT - THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY OR REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM.

Note - The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim. VA may obtain additional medical information, including an examination, if necessary, to complete VA's review of the veteran's application. VA reserves the right to confirm the authenticity of ALL questionnaires completed by providers. **It is intended that this questionnaire will be completed by the Veteran's provider. This evaluation should be based on DSM-5 diagnostic criteria.**

NOTE: If the Veteran experiences a mental health emergency during the interview, please terminate the interview and obtain help, using local resources as appropriate. You may also contact the Veterans Crisis Line at 1-800-273-TALK (8255). Stay on the Crisis Line until help can link the Veteran to emergency care.

NOTE: In order to conduct an initial examination for mental disorders, the examiner must meet one of the following criteria: a board-certified or board-eligible psychiatrist; a licensed doctorate-level psychologist; a doctorate-level mental health provider under the close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; a psychiatry resident under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist; or a clinical or counseling psychologist completing a one-year internship or residency (for purposes of a doctorate-level degree) under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

In order to conduct a review examination for mental disorders, the examiner must meet one of the criteria from above, OR be a licensed clinical social worker (LCSW), a nurse practitioner, a clinical nurse specialist, or a physician assistant, under close supervision of a board-certified or board-eligible psychiatrist or licensed doctorate-level psychologist.

This Questionnaire is to be completed for both initial and review mental disorder(s) claims.

Are you completing this Disability Benefits Questionnaire at the request of:

☐ Veteran/Claimant

☒ Other: please describe: Dept of Veteran Affairs

Are you a VA Healthcare provider? ○ Yes ◉ No

Is the Veteran regularly seen as a patient in your clinic? ○ Yes ◉ No

Was the Veteran examined in person? ○ Yes ◉ No

If no, how was the examination conducted? Approved VA Telehealth Option

SECTION I: DIAGNOSIS

1. DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A MENTAL DISORDER(S)?

☒ YES ☐ NO

ICD CODE: F41.1

NOTE: If the Veteran has a diagnosis of an eating disorder, complete the Eating Disorders Questionnaire, in lieu of this questionnaire.
NOTE: If the Veteran has a diagnosis of PTSD, the Initial PTSD Questionnaire must be completed by a VHA staff or contract examiner in lieu of this questionnaire.

If the Veteran currently has one or more mental disorders that conform to DSM-5 criteria, provide all diagnoses:

MENTAL DISORDER DIAGNOSIS #1 Generalized Anxiety Disorder ICD CODE: F41.1

COMMENTS, IF ANY:

MENTAL DISORDER DIAGNOSIS #2 ICD CODE:

COMMENTS, IF ANY:

MENTAL DISORDER DIAGNOSIS #3 ICD CODE:

COMMENTS, IF ANY:

IF ADDITIONAL DIAGNOSES, LIST USING ABOVE FORMAT:

1B. MEDICAL DIAGNOSES RELEVANT TO THE UNDERSTANDING OR MANAGEMENT OF THE MENTAL HEALTH DISORDER (to include TBI):

ICD CODE:

COMMENTS, IF ANY:

2. DIFFERENTIATION OF SYMPTOMS

2A. DOES THE VETERAN HAVE MORE THAN ONE MENTAL DISORDER DIAGNOSED?

☐ YES ☒ NO *(If "Yes," complete the following question 2B)*

2B. IS IT POSSIBLE TO DIFFERENTIATE WHAT SYMPTOM(S) IS/ARE ATTRIBUTABLE TO EACH DIAGNOSIS?

☐ YES ☐ NO ☒ NOT APPLICABLE

(If "No," provide reason):

(If "Yes," list which symptoms are attributable to each diagnosis and discuss whether there is any clinical association between these diagnoses):

2C. DOES THE VETERAN HAVE A DIAGNOSED TRAUMATIC BRAIN INJURY (TBI)?

☐ YES ☒ NO ☐ NOT SHOWN IN RECORDS REVIEWED *(If "Yes," complete the following question, 2D)*

Comments, if any:

2D. IS IT POSSIBLE TO DIFFERENTIATE WHAT SYMPTOM(S) IS/ARE ATTRIBUTABLE TO TBI AND ANY NON-TBI MENTAL HEALTH DIAGNOSIS?

☐ YES ☐ NO ☒ NOT APPLICABLE

(If "No," provide reason):

(If "Yes," list which symptoms are attributable to TBI and which symptoms are attributable to a non-TBI mental health diagnosis):

3. OCCUPATIONAL AND SOCIAL IMPAIRMENT

3A. WHICH OF THE FOLLOWING BEST SUMMARIZES THE VETERAN'S LEVEL OF OCCUPATIONAL AND SOCIAL IMPAIRMENT WITH REGARD TO ALL MENTAL DIAGNOSES? *(Check only one)*

- ☐ No mental disorder diagnosis
- ☐ A mental condition has been formally diagnosed, but symptoms are not severe enough either to interfere with occupational and social functioning or to require continuous medication
- ☐ Occupational and social impairment due to mild or transient symptoms which decrease work efficiency and ability to perform occupational tasks only during periods of significant stress, or; symptoms controlled by medication
- ☐ Occupational and social impairment with occasional decrease in work efficiency and intermittent periods of inability to perform occupational tasks, although generally functioning satisfactorily, with normal routine behavior, self-care and conversation
- ☒ Occupational and social impairment with reduced reliability and productivity
- ☐ Occupational and social impairment with deficiencies in most areas, such as work, school, family relations, judgment, thinking and/or mood
- ☐ Total occupational and social impairment

3B. FOR THE INDICATED OCCUPATIONAL AND SOCIAL IMPAIRMENT, IS IT POSSIBLE TO DIFFERENTIATE WHICH IMPAIRMENT IS CAUSED BY EACH MENTAL DISORDER?

☐ YES ☐ NO ☒ NOT APPLICABLE

(If "No," provide reason):

(If "Yes," list which occupational and social impairment is attributable to each diagnosis):

3C. IF A DIAGNOSIS OF TBI EXISTS, IS IT POSSIBLE TO DIFFERENTIATE WHICH OCCUPATIONAL AND SOCIAL IMPAIRMENT INDICATED ABOVE IS CAUSED BY THE TBI?

☐ YES ☐ NO ☒ NOT APPLICABLE

(If "No," provide reason):

(If "Yes," list which impairment is attributable to TBI and which is attributable to any non-TBI mental health diagnosis):

SECTION II: CLINICAL FINDINGS:

Evidence reviewed:

○ No records were reviewed

◉ Records reviewed

Please identify the evidence reviewed (e.g. service treatment records, VA treatment records, private treatment records) and the date range.

VA e-folder

2. HISTORY

NOTE: Initial examination require pre-military, military, and post-military history. If this is a review examination, only indicate any relevant history since prior exam.

2A. RELEVANT SOCIAL/MARITAL/FAMILY HISTORY *(PRE-MILITARY, MILITARY, AND POST-MILITARY)*

Born and raised in Tampa Florida. Raised by both biological parents and a younger sister. Father was in the restaurant business and mother worked at Publix and attended the children. Married high school sweetheart in 1997 and they have 3 children together, 2 girls and 1 boy. Currently Live in NYC

2B. RELEVANT OCCUPATIONAL AND EDUCATIONAL HISTORY *(PRE-MILITARY, MILITARY, AND POST-MILITARY)*

Graduated High School in 1995 with a 4.0 GPA.

2C. RELEVANT MENTAL HEALTH HISTORY, TO INCLUDE PRESCRIBED MEDICATIONS AND FAMILY MENTAL HEALTH *(PRE-MILITARY, MILITARY, AND POST-MILITARY)*

Denied any family history of mental health prior to enlistment. Veteran reports difficulty on deployment being away from his wife and children and haunted by the lives he took while downrange. Currently working with a MH Provider to address medication concerns.

2D. RELEVANT LEGAL AND BEHAVIORAL HISTORY *(PRE-MILITARY, MILITARY, AND POST-MILITARY)*

Veteran denies any legal or behavioral issues during service as well as pre and post service.

2E. RELEVANT SUBSTANCE ABUSE HISTORY *(PRE-MILITARY, MILITARY, AND POST-MILITARY)*

Veteran reports he started drinking down range and is trying to give it up as it causes fights with his wife

2F. OTHER, if any:

SECTION III: SYMPTOMS

FOR VA RATING PURPOSES, CHECK ALL SYMPTOMS THAT APPLY TO THE VETERAN'S DIAGNOSES

- [x] Depressed mood
- [x] Anxiety
- [ ] Suspiciousness
- [ ] Panic attacks that occur weekly or less often
- [ ] Panic attacks more than once a week
- [ ] Near-continuous panic or depression affecting the ability to function independently, appropriately and effectively
- [x] Chronic sleep impairment
- [x] Mild memory loss, such as forgetting names, directions or recent events
- [ ] Impairment of short and long term memory, for example, retention of only highly learned material, while forgetting to complete tasks
- [ ] Memory loss for names of close relatives, own occupation, or own name
- [ ] Flattened affect
- [ ] Circumstantial, circumlocutory or stereotyped speech
- [ ] Speech intermittently illogical, obscure, or irrelevant
- [ ] Difficulty in understanding complex commands
- [ ] Impaired judgment
- [ ] Impaired abstract thinking
- [ ] Gross impairment in thought processes or communication
- [x] Disturbances of motivation and mood
- [x] Difficulty in establishing and maintaining effective work and social relationships
- [x] Difficulty adapting to stressful circumstances, including work or a work like setting
- [ ] Inability to establish and maintain effective relationships
- [x] Suicidal ideation
- [ ] Obsessional rituals which interfere with routine activities
- [ ] Impaired impulse control, such as unprovoked irritability with periods of violence
- [ ] Spatial disorientation
- [ ] Persistent delusions or hallucinations
- [ ] Grossly inappropriate behavior
- [ ] Persistent danger of hurting self or others
- [ ] Neglect of personal appearance and hygiene
- [ ] Intermittent inability to perform activities of daily living, including maintenance of minimal personal hygiene
- [ ] Disorientation to time or place

SECTION IV: BEHAVIORAL OBSERVATIONS

Claimant arrived to virtual appointment on time and was fully alert and oriented. Claimant was guarded in speech and took some time to have him open up and give more than 1 word answers. Eventually claimant opened up and explained that he is feeling beaten down due to "Thoughts that are not his own" He explained that he doesn't wish to end his life but he gets these thoughts telling him that it would be better to end his life just like he ended the lives of so many others. Veteran became tearful as he explained that his wife does not know everything that he experienced while in the service and that if she knew everything she would look at him different or leave him, so he keeps it bottled up. Further discussion on this affirms that the veteran does not have any intentions of harming himself or others.

SECTION V: OTHER SYMPTOMS

4. DOES THE VETERAN HAVE ANY OTHER SYMPTOMS ATTRIBUTABLE TO MENTAL DISORDERS THAT ARE NOT LISTED ABOVE?

☐ YES ☒ NO *(If "Yes," describe)*

SECTION VI: COMPETENCY

NOTE: For VA purposes, a mentally incompetent person is one who because of injury or disease lacks the mental capacity to contract or to manage his or her own affairs, including disbursement of funds without limitation.

IS THE VETERAN CAPABLE OF MANAGING HIS OR HER FINANCIAL AFFAIRS?

☒ YES ☐ NO (If "No," specify each injury or disease resulting in incompetency and provide a rationale to support this finding):

SECTION VII: REMARKS

REMARKS *(Including any testing results), if any:*

For the claimant's claimed condition of Anxiety Disorder please refer to the Diagnosis section.

The suicide risk level is not at elevated acute risk

SECTION VIII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

8A. Examiner's signature:	8B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C):
Electronically signed	POWELL CYNTHIA A. PSY. D Psychology

8C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice):	8D. Date Signed:
Psychology/Psychiatry	8/11/2022

8E. Examiner's phone/fax numbers:	8F. National Provider Identifier (NPI) number:	8G. Medical license number and state:
910-219-7827 Fax 949-89-2281	1033427182	4766 nc

8H. Examiner's address:

7 Office Park Dr Ste 1 Jacksonville NC 28546

Shoulder and Arm Conditions
Disability Benefits Questionnaire

FIRST NAME, LAST NAME, MIDDLE NAME *(SUFFIX):*	SOCIAL SECURITY NUMBER/FILE NUMBER:	TODAY'S DATE:
CLINT BARTON, DENNIS	011-25-2006	08/11/2022
HOME ADDRESS: 890 FIFTH AVENUE NEW YORK, NY 10001	**EXAMINING LOCATION AND ADDRESS:** VES	
HOME TELEPHONE: 336-867-5309		

CONTRACTOR:	VES NUMBER:	VA CLAIM NUMBER:
VES	22622370012	

NOTE TO EXAMINER – The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

Is this questionnaire being completed in conjunction with VA 21-2507, C&P examination request?
[YES]

How was the examination completed? (check all that apply)
[X] In-person examination
[X] Records reviewed
[] Examination via approved video telehealth
[] Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

Indicate the 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 questionnaire and such an examination will likely provide no additional relevant evidence.

[] Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

Evidence reviewed (check all that apply):
[] Not requested
[] VA claims file (hard copy paper C-file)
[X] VA e-folder
[] VA electronic health record
[] Other (please identify other evidence reviewed):

[] No records were reviewed

Evidence comments:

All available records were reviewed and findings considered when completing this DBQ.

DOMINANT HAND

Dominant hand:
[RIGHT]

SECTION I - DIAGNOSIS

NOTE: These are condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. List the claimed conditions that pertain to this questionnaire:

For the Claimed Compensation Condition of – BILATERAL SHOULDER CONDITION

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

1B. Select diagnoses associated with the claimed condition(s) (check all that apply):

[] The Veteran does not have a current diagnosis associated with any claimed conditions listed above. (Explain your findings and reasons in the remarks section)

		Side affected:	ICD Code:	Date of diagnosis:			
[X]	Shoulder strain	[BOTH]	S46.911A	Right:	8/11/2022	Left:	
[]	Shoulder impingement syndrome	[]		Right:		Left:	
[]	Bicipital tendonitis	[]		Right:		Left:	
[]	Bicipital tendon tear	[]		Right:		Left:	
[]	Rotator cuff tendonitis	[]		Right:		Left:	
[]	Rotator cuff tear	[]		Right:		Left:	
[]	Labral tear, including SLAP (superior labral anterior-posterior lesion)	[]		Right:		Left:	
[]	Subacromial/subdeltoid bursitis	[]		Right:		Left:	
[]	Glenohumeral joint osteoarthritis	[]		Right:		Left:	
[]	Acromioclavicular joint osteoarthritis	[]		Right:		Left:	
[]	Ankylosis of glenohumeral articulations (shoulder joint)	[]		Right:		Left:	
[]	Glenohumeral joint instability	[]		Right:		Left:	
[]	Glenohumeral joint dislocation/ recurrent dislocation	[]		Right:		Left:	
[]	Shoulder joint replacement (total shoulder arthroplasty/hemiarthroplasty)	[]		Right:		Left:	
[]	Acromioclavicular joint separation	[]		Right:		Left:	
[]	Degenerative arthritis, other than post-traumatic	[]		Right:		Left:	
[]	Arthritis, gonorrheal	[]		Right:		Left:	
[]	Arthritis, pneumococcic	[]		Right:		Left:	
[]	Arthritis, streptococcic	[]		Right:		Left:	
[]	Arthritis, syphilitic	[]		Right:		Left:	
[]	Arthritis, rheumatoid (multi-joints)	[]		Right:		Left:	
[]	Post-traumatic arthritis	[]		Right:		Left:	
[]	Arthritis, typhoid	[]		Right:		Left:	
[]	Other specified forms of arthropathy (excluding gout) (specify)						
[]	Osteoporosis, residuals of	[]		Right:		Left:	

[]	Osteomalacia, residuals of	[]	_____	Right: _____	Left: _____	
[]	Bones, neoplasm, benign	[]	_____	Right: _____	Left: _____	
[]	Osteitis deformans	[]	_____	Right: _____	Left: _____	
[]	Gout	[]	_____	Right: _____	Left: _____	
[]	Bursitis	[]	_____	Right: _____	Left: _____	
[]	Myositis	[]	_____	Right: _____	Left: _____	
[]	Heterotopic ossification	[]	_____	Right: _____	Left: _____	
[]	Tendinopathy (select one if known)	[]	_____	Right: _____	Left: _____	
	[] Tendinitis	[]	_____	_____	_____	
	[] Tendinosis	[]	_____	Right: _____	Left: _____	
	[] Tenosynovitis	[]	_____	Right: _____	Left: _____	
[]	Inflammatory - other types (specify)	[]		Right:	Left:	

[] Other (specify)
Other diagnosis #1

ICD Code: Date of diagnosis:
Side affected: [] _____ Right: _____ Left: _____

Other diagnosis #2

ICD Code: Date of diagnosis:
Side affected: [] _____ Right: _____ Left: _____

If there are additional diagnoses that pertain to shoulder and/or arm conditions, list using above format:

SECTION II – MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's shoulder and/or arm condition (brief summary):

Date of onset: 2018

Details of onset: He states he injured his right shoulder in 2018. He then began to use his left arm more to compensate for the right shoulder pain and noticed he began to have left shoulder pain.

Course of the condition since onset:
[] Progressed/Worsened
[X] Stayed the same
[] Improved
[] Resolved
[] Other, please describe:

Current symptoms (or state if the condition has resolved): He currently has a constant dull pain

Any treatment, medications or surgery? he has had PT in the past. he uses tylenol, ice and biofreeze for pain

2B. Does the Veteran report flare-ups of the shoulder and/or arm?
[YES]

If yes, document the Veteran's description of the flare-ups he or she experiences, including the frequency, duration, characteristics, precipitating and alleviating factors, severity and/or extent of functional impairment he or she experiences during a flare-up of symptoms:

Frequency: once a month

Duration: 2-3 days

Characteristics: sharp pain

Precipitating factors: lifting above his head

Alleviating factors: rest

Severity: [SEVERE]

Extent of functional impairment he or she experiences during a flare-up of symptoms: he is unable to lift more than 10 lbs

2C. Does the Veteran report having any functional loss or functional impairment of the joint or extremity being evaluated on this questionnaire, including but not limited to after repeated use over time?
[YES]

If yes, document the Veteran's description of functional loss or functional impairment in his/her own words:

He is unable to lift more than 25 lbs, work above shoulder height

SECTION III –RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION

There are several separate parameters requested for describing function of a joint. The question "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 repetitive use over time or during a flare-up; however, this is not always feasible.

Information regarding joint function on repetitive use is broken up into two subsets. The first subset is based on observed repetitive use, and the second is based on functional loss associated with repeated use over time. The observed repetitive use section initially asks for objective findings after three or more repetitions of range of motion testing. The second subset 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. This takes into account not only the objective findings noted on the examination, but also the subjective history provided by the claimant, as well as review of the available medical evidence.

Optimally, a description of any additional loss of function should be provided - such as what the degrees of range of motion would be opined to look like after repetitive use over time. However, when this is not feasible, an "as 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 ROM measurements

RIGHT SHOULDER

[]

If “Unable to test” or “Not indicated” please explain:

If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than a shoulder/arm condition, such as age, body habitus, neurologic disease), please describe:

If abnormal, does the range of motion itelf contribute to a functional loss?
[]

(if yes, please explain)

NOTE: For any joint condition, examiners should address pain on both passive and active motion, and on both weight-bearing and nonweight-bearing. Examiners should also test the contralateral joint (unless medically contraindicated). If testing cannot be performed or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation

must be given below. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).

Can testing be performed?
[No]

If no, provide an explanation:

If this is the unclaimed joint, is it:
[damaged]

If undamaged, range of motion testing must be conducted.

Active Range of Motion (ROM) – Perform active range of motion and provide the ROM values.

Flexion endpoint (180 degrees):	110	degrees
Abduction endpoint (180 degrees):	105	degrees
Internal rotation endpoint (90 degrees):	75	degrees
External rotation endpoint (90 degrees):	60	degrees

If noted on examination, which ROM exhibited pain? (select all that apply):
[X] Flexion
[X] Abduction
[X] Internal rotation
[X] External rotation

If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.
_____ Flexion degree endpoint (if different than above)
_____ Abduction degree endpoint (if different than above)
_____ Internal rotation degree endpoint (if different than above)
_____ External rotation degree endpoint (if different than above)

Passive Range of Motion - Perform passive ROM and provide the ROM values.

Flexion endpoint (180 degrees):	_____	degrees	[X] Same as active ROM
Abduction endpoint (180 degrees):	_____	degrees	[X] Same as active ROM
Internal rotation endpoint (90 degrees):	_____	degrees	[X] Same as active ROM
External rotation endpoint (90 degrees):	_____	degrees	[X] Same as active ROM

If noted on examination, which ROM exhibited pain? (select all that apply):
[X] Flexion
[X] Abduction
[X] Internal rotation
[X] External rotation

If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.
_____ Flexion degree endpoint (if different than above)
_____ Abduction degree endpoint (if different than above)
_____ Internal rotation degree endpoint (if different than above)
_____ External rotation degree endpoint (if different than above)

Is there evidence of pain?
[YES]

If yes check all that apply.
[] Weight-bearing
[] Nonweight-bearing

[X] Active motion
[X] Passive motion
[] On rest/non-movement

[X] Does not result in/cause functional loss

Is there evidence of pain?
[]

If yes check all that apply.
[] Weight-bearing
[] Nonweight-bearing

[] Active motion
[] Passive motion
[] On rest/non-movement

[] Does not result in/cause functional loss
[] Causes functional loss (if checked describe in the comments box below)

Comments:

Is there objective evidence of crepitus?
[]

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?
[]

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

Location:

Severity:

Relationship to condition(s):

LEFT SHOULDER

[]

If "Unable to test" or "Not indicated" please explain:

If ROM is outside of "normal" range, but is normal for the Veteran (for reasons other than a shoulder/arm condition, such as age, body habitus, neurologic disease), please describe:

If abnormal, does the range of motion itself contribute to a functional loss?
[NO]

(if yes, please explain)

NOTE: For any joint condition, examiners should address pain on both passive and active motion, and on both weight-bearing and nonweight-bearing. Examiners should also test the contralateral joint (unless medically contraindicated). If testing cannot be performed or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation must be given below. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).

Can testing be performed?
[]

If no, provide an explanation:

If this is the unclaimed joint, is it:
[]

If undamaged, range of motion testing must be conducted.

Active Range of Motion (ROM) – Perform active range of motion and provide the ROM values.

Flexion endpoint (180 degrees): 180 degrees
Abduction endpoint (180 degrees): 180 degrees
Internal rotation endpoint (90 degrees): 90 degrees
External rotation endpoint (90 degrees): 90 degrees

If noted on examination, which ROM exhibited pain? (select all that apply):
[X] Flexion
[X] Abduction
[X] Internal rotation
[X] External rotation

If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.
_____ Flexion degree endpoint (if different than above)
_____ Abduction degree endpoint (if different than above)
_____ Internal rotation degree endpoint (if different than above)
_____ External rotation degree endpoint (if different than above)

Passive Range of Motion - Perform passive ROM and provide the ROM values.

Flexion endpoint (180 degrees):	_____	degrees	[X] Same as active ROM
Abduction endpoint (180 degrees):	_____	degrees	[X] Same as active ROM
Internal rotation endpoint (90 degrees):	_____	degrees	[X] Same as active ROM
External rotation endpoint (90 degrees):	_____	degrees	[X] Same as active ROM

If noted on examination, which ROM exhibited pain? (select all that apply):
[X] Flexion
[X] Abduction
[X] Internal rotation
[X] External rotation

If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.
_____ Flexion degree endpoint (if different than above)
_____ Abduction degree endpoint (if different than above)
_____ Internal rotation degree endpoint (if different than above)
_____ External rotation degree endpoint (if different than above)

Is there evidence of pain?
[YES]

If yes check all that apply.
[] Weight-bearing
[] Nonweight-bearing

[X] Active motion
[X] Passive motion
[] On rest/non-movement

[X] Does not result in/cause functional loss

[] Causes functional loss (if checked describe in the comments box below)

Comments:

Is there objective evidence of crepitus?
[NO]

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue?
[YES]

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

Location: anterior and superior joint TTP

Severity: mild

Relationship to condition(s): related to rotator cuff tendonitis

3B. Observed repetitive use ROM

RIGHT SHOULDER

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

If no, please explain:

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

If yes, please respond to the following after the completion of the three repetitions:
Flexion endpoint (180 degrees): _____ degrees
Abduction endpoint (180 degrees): _____ degrees
Internal rotation endpoint (90 degrees): _____ degrees
External rotation endpoint (90 degrees): _____ degrees

Select factors that cause this functional loss. (check all that apply):
[] N/A
[] Pain
[] Fatigability
[] Weakness
[] Lack of endurance
[] Incoordination
[] Other

LEFT SHOULDER

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

If no, please explain:

Is there additional loss of function or range of motion after three repetitions?
[NO]

If yes, please respond to the following after the completion of the three repetitions:
Flexion endpoint (180 degrees): _____ degrees

Abduction endpoint (180 degrees): _____ degrees
Internal rotation endpoint (90 degrees): _____ degrees
External rotation endpoint (90 degrees): _____ degrees

Select factors that cause this functional loss. (check all that apply):
[] N/A
[] Pain
[] Fatigability
[] Weakness
[] Lack of endurance
[] Incoordination
[] Other

NOTE: When pain is associated with movement, the examiner must give a statement on whether pain could significantly limit functional ability during flare-ups and/or after repeated use over time in terms of additional loss of range of motion. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare-ups – even if not directly observed during a flare-up and/or after repeated use over time.

3C. Repeated use over time

RIGHT SHOULDER

Is the Veteran being examined immediately after repeated use over time?
[]

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time?
[]

Select factors that cause this functional loss. (check all that apply):
[] N/A
[] Pain
[] Fatigability
[] Weakness
[] Lack of endurance
[] Incoordination
[] Other

Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran.

Flexion endpoint (180 degrees): _____ degrees
Abduction endpoint (180 degrees): _____ degrees
Internal rotation endpoint (90 degrees): _____ degrees
External rotation endpoint (90 degrees): _____ degrees

The examiner should provide the estimated range of motion based on a review of all procurable information – to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence here. (Must be specific to the case and based on all procurable evidence.)

LEFT SHOULDER

Is the Veteran being examined immediately after repeated use over time?
[NO]

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time?
[YES]

Select factors that cause this functional loss. (check all that apply):
[] N/A
[X] Pain
[] Fatigability
[] Weakness
[] Lack of endurance
[] Incoordination
[] Other

Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran.

Flexion endpoint (180 degrees): _____ degrees
Abduction endpoint (180 degrees): _____ degrees
Internal rotation endpoint (90 degrees): _____ degrees
External rotation endpoint (90 degrees): _____ degrees

The examiner should provide the estimated range of motion based on a review of all procurable information – to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence here. (Must be specific to the case and based on all procurable evidence.)

3D. Flare-ups

RIGHT SHOULDER

Is the examination being conducted during a flare-up?
[]

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination significantly limits functional ability with flare-ups?
[]

Select factors that cause this functional loss. (check all that apply):
[] N/A
[] Pain
[] Fatigability
[] Weakness
[] Lack of endurance
[] Incoordination
[] Other

Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran.

Flexion endpoint (180 degrees): _____ degrees
Abduction endpoint (180 degrees): _____ degrees
Internal rotation endpoint (90 degrees): _____ degrees
External rotation endpoint (90 degrees): _____ degrees

The examiner should provide the estimated range of motion based on a review of all procurable information – to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence here. (Must be specific to the case and based on all procurable evidence.)

LEFT SHOULDER

Is the examination being conducted during a flare-up?
[NO]

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination significantly limits functional ability with flare-ups?
[YES]

Select factors that cause this functional loss. (check all that apply):
[] N/A
[X] Pain
[] Fatigability
[] Weakness
[] Lack of endurance
[] Incoordination
[] Other

Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran.

Flexion endpoint (180 degrees): 170 degrees
Abduction endpoint (180 degrees): 170 degrees
Internal rotation endpoint (90 degrees): 90 degrees
External rotation endpoint (90 degrees): 90 degrees

The examiner should provide the estimated range of motion based on a review of all procurable information – to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence here. (Must be specific to the case and based on all procurable evidence.)

3E. Additional factors contributing to disability

RIGHT SIDE
In addition to those addressed above, are there additional contributing factors of disability? Select all that apply and describe:

[X] None
[] Interference with sitting
[] Interference with standing
[] Swelling
[] Disturbance of locomotion
[] Deformity
[] Less movement than normal
[] More movement than normal
[] Weakened movement
[] Atrophy of disuse
[] Instability of station
[] Other, describe:

Please describe additional contributing factors of disability here:

LEFT SIDE
In addition to those addressed above, are there additional contributing factors of disability? Select all that apply and describe:

[X] None
[] Interference with sitting
[] Interference with standing
[] Swelling
[] Disturbance of locomotion
[] Deformity
[] Less movement than normal
[] More movement than normal
[] Weakened movement
[] Atrophy of disuse
[] Instability of station
[] Other, describe:

Please describe additional contributing factors of disability here:

SECTION IV - MUSCLE ATROPHY

4A. Does the Veteran have muscle atrophy?
RIGHT SIDE
[]

LEFT SIDE
[NO]

4B. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section?
RIGHT SIDE
[]

If no, provide rationale:

LEFT SIDE
[]

If no, provide rationale:

4C. For any muscle atrophy due to a diagnosis listed in Section 1, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.

[] Right upper extremity (specify location of measurement such as “10cm above the anterior elbow crease” here):

Circumference of more normal side: _____ cm
Circumference of atrophied side: _____ cm

[] Left upper extremity (specify location of measurement such as "10cm above the anterior elbow crease" here):

Circumference of more normal side: _____ cm
Circumference of atrophied side: _____ cm

SECTION V – ANKYLOSIS

NOTE: Ankylosis is the immobilization of a joint due to disease, injury or surgical procedure.

5A Is there ankylosis of the scapulohumeral (glenohumeral) articulation (shoulder joint) – (i.e., the scapula and humerus move as one piece)?

RIGHT SIDE
[]

If yes, indicate the severity of ankylosis:
[] Ankylosis in abduction up to 60 degrees; can reach mouth and head (favorable ankylosis)
[] Ankylosis in abduction between favorable and unfavorable (intermediate ankylosis)
[] Ankylosis in abduction at 25 degrees or less from side (unfavorable ankylosis)

LEFT SIDE
[NO]

If yes, indicate the severity of ankylosis:
[] Ankylosis in abduction up to 60 degrees; can reach mouth and head (favorable ankylosis)
[] Ankylosis in abduction between favorable and unfavorable (intermediate ankylosis)
[] Ankylosis in abduction at 25 degrees or less from side (unfavorable ankylosis)

5B. Indicate angle of ankylosis in degrees of abduction:

RIGHT SIDE:
_____ degrees

LEFT SIDE:
_____ degrees

5C. If ankylosed, is there involvement of Muscle Group I (trapezius, levator scapulae, serratus magnus) and II (pectoralis major II (costosternal), latissimus dorsi and teres major, pectoralis minor, rhomboid)?

RIGHT SIDE
[]

If yes, complete the Muscle Injuries questionnaire.

LEFT SIDE
[]

If yes, complete the Muscle Injuries questionnaire.

SECTION VI – ROTATOR CUFF CONDITIONS

6A. Complete the following:

RIGHT SHOULDER

Hawkin's Impingement Test:
Forward flex the arm to 90 degrees with the elbow bent to 90 degrees. Internally rotate arm. Pain on internal rotation indicates a positive test; may signify rotator cuff tendinopathy or tear.
[]

Empty Can Test:
Abduct arm to 90 degrees and forward flex 30 degrees. Patient turns thumbs down and resists downward force applied by the examiner. Weakness indicates a positive test; may indicate rotator cuff pathology, including supraspinatus tendinopathy or tear.
[]

External rotation/infraspinatus strength test:
Patient holds arms at side with elbow flexed 90 degrees. Patient externally rotates against resistance. Weakness indicates a positive test; may be associated with infraspinatus tendinopathy or tear.
[]

Lift-off subscapularis test:
Patient internally rotates arm behind lower back, pushes against examiner's hand. Weakness indicates a positive test; may indicate subscapularis tendinopathy or tear.
[]

LEFT SHOULDER

Hawkin’s Impingement Test:
Forward flex the arm to 90 degrees with the elbow bent to 90 degrees. Internally rotate arm. Pain on internal rotation indicates a positive test; may signify rotator cuff tendinopathy or tear.
[POSITIVE]

Empty Can Test:
Abduct arm to 90 degrees and forward flex 30 degrees. Patient turns thumbs down and resists downward force applied by the examiner. Weakness indicates a positive test; may indicate rotator cuff pathology, including supraspinatus tendinopathy or tear.
[POSITIVE]

External rotation/infraspinatus strength test:
Patient holds arms at side with elbow flexed 90 degrees. Patient externally rotates against resistance. Weakness indicates a positive test; may be associated with infraspinatus tendinopathy or tear.
[POSITIVE]

Lift-off subscapularis test:
Patient internally rotates arm behind lower back, pushes against examiner's hand. Weakness indicates a positive test; may indicate subscapularis tendinopathy or tear.
[POSITIVE]

6B. If unable to test, is a rotator cuff condition suspected?

RIGHT SHOULDER
[]

If yes, please describe:

LEFT SHOULDER
[]

If yes, please describe:

SECTION VII – SHOULDER INSTABILITY, DISLOCATION OR LABRAL PATHOLOGY

7A. Complete the following:

RIGHT SHOULDER
Crank Apprehension and Relocation Test:
With patient supine, abduct patient’s arm to 90 degrees and flex elbow 90 degrees. Pain and sense of instability with further external rotation may indicate shoulder instability.

[]

LEFT SHOULDER
Crank Apprehension and Relocation Test:
With patient supine, abduct patient's arm to 90 degrees and flex elbow 90 degrees. Pain and sense of instability with further external rotation may indicate shoulder instability.
[NEGATIVE]

7B. If unable to test, is shoulder instability, dislocation or labral pathology suspected?

RIGHT SHOULDER
[]

If yes, please describe

LEFT SHOULDER
[]

If yes, please describe

7C. Is there shoulder instability, dislocation or labral pathology?

RIGHT SHOULDER
[]

LEFT SHOULDER
[NO]

7D. Does the Veteran have mechanical symptoms (clicking, catching, etc.)?

RIGHT SHOULDER
[]

LEFT SHOULDER
[NO]

7E. Are there current residuals of recurrent dislocation (subluxation) of the glenohumeral (scapulohumeral) joint?

RIGHT SHOULDER
[]

If yes, check all that apply:
[] Infrequent episodes and guarding of movement only at shoulder level (flexion and/or abduction at 90°)
[] Frequent episodes and guarding of all arm movements

Affects range of motion?
[]

LEFT SHOULDER
[]

If yes, check all that apply:
[] Infrequent episodes and guarding of movement only at shoulder level (flexion and/or abduction at 90°)
[] Frequent episodes and guarding of all arm movements

Affects range of motion?
[]

SECTION VIII – CLAVICLE, SCAPULA, ACROMIOCLAVICULAR (AC) JOINT AND STERNOCLAVICULAR JOINT CONDITIONS

8A. Complete the following:

RIGHT SHOULDER
Crossbody adduction test:
Passively adduct arm across the patient's body toward the contralateral shoulder. Pain may indicate acromioclavicular joint pathology.
[]

LEFT SHOULDER
Crossbody adduction test:
Passively adduct arm across the patient's body toward the contralateral shoulder. Pain may indicate acromioclavicular joint pathology.
[NEGATIVE]

8B. If unable to test, is a clavicle, scapula, acromioclavicular (AC) joint or sternoclavicular joint condition suspected?

RIGHT SHOULDER
[]

If yes, please describe:

LEFT SHOULDER
[]

If yes, please describe:

8C. Is there a clavicle, scapula, acromioclavicular (AC) joint, sternoclavicular joint condition or other impairment?

RIGHT SHOULDER
[]

If yes, indicate severity:
[] Malunion of clavicle or scapula
[] Nonunion of clavicle or scapula without loose movement
[] Nonunion of clavicle or scapula with loose movement
[] Dislocation (acromioclavicular separation or sternoclavicular dislocation)
[] Other (describe):

LEFT SHOULDER
[NO]

If yes, indicate severity:
[] Malunion of clavicle or scapula
[] Nonunion of clavicle or scapula without loose movement
[] Nonunion of clavicle or scapula with loose movement
[] Dislocation (acromioclavicular separation or sternoclavicular dislocation)
[] Other (describe):

8D. Does the clavicle or scapula condition affect range of motion of the shoulder (glenohumeral joint)?

RIGHT SHOULDER
[]

LEFT SHOULDER
[]

8E. Is there tenderness on palpation of the AC joint?

RIGHT SHOULDER
[]

LEFT SHOULDER
[NO]

SECTION IX – CONDITIONS OR IMPAIRMENTS OF THE HUMERUS

9A. Does the Veteran have loss of head (flail shoulder), nonunion (false flail shoulder), or fibrous union of the humerus?

RIGHT SHOULDER
[]

If yes, check all that apply:
[] Loss of head (flail shoulder)
[] Nonunion (false flail shoulder)
[] Fibrous union

LEFT SHOULDER
[NO]

If yes, check all that apply:
[] Loss of head (flail shoulder)
[] Nonunion (false flail shoulder)
[] Fibrous union

9B. Does the Veteran have malunion of the humerus with moderate or marked deformity?

RIGHT SHOULDER
[]

If yes, indicate severity:
[] Moderate deformity
[] Marked deformity

LEFT SHOULDER
[NO]

If yes, indicate severity:
[] Moderate deformity
[] Marked deformity

9C. Does the humerus condition affect range of motion of the shoulder (glenohumeral joint)?

RIGHT SHOULDER
[]

LEFT SHOULDER
[]

SECTION X - SURGICAL PROCEDURES

10. Indicate any surgical procedures that the Veteran has had performed and provide the additional information as requested (check all that apply):

RIGHT SIDE:
[] No surgery

[] Total shoulder joint replacement
Date of surgery: _____
Residuals:
[] None
[] Intermediate degrees of residual weakness, pain or limitation of motion
[] Chronic residuals consisting of severe painful motion or weakness
[] Other residuals, describe:

[] Arthroscopic or other shoulder surgery
Date of surgery: _____
Type of surgery:

Describe residuals:

LEFT SIDE:
[X] No surgery

[] Total shoulder joint replacement
Date of surgery: _____
Residuals:
[] None
[] Intermediate degrees of residual weakness, pain or limitation of motion
[] Chronic residuals consisting of severe painful motion or weakness
[] Other residuals, describe:

[] Arthroscopic or other shoulder surgery
Date of surgery: _____
Type of surgery:
Describe residuals:

SECTION XI - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

11A. Does the Veteran have any other pertinent physical findings, complications, signs, or symptoms related to any conditions listed in the diagnosis section above?
[NO]

If yes, describe (brief summary):

11B. Does the Veteran have any scars or other disfigurement (of the skin) related to any conditions or to the treatment of any conditions listed in the diagnosis section?
[NO]

If yes, also complete the appropriate dermatological questionnaire.

11C. Comments, if any:

SECTION XII - ASSISTIVE DEVICES

12A. Does the Veteran use any assistive devices?
[NO]

If yes, identify assistive devices used. Check all that apply and indicate frequency:
[] Brace Frequency of use: []
[] Other, describe: _____ Frequency of use: []

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

Specify the condition:

Indicate the side: []

Identify the assistive device used for each condition:

SECTION XIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

NOTE: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prosthesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check "yes" and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

13A. Due to the Veteran's shoulder or arm condition(s), is there functional impairment of an extremity such that no effective functions remain other than that which would be equally well-served by an amputation with prosthesis (functions of the upper extremity include grasping, manipulation, etc.)?
[NO]

If yes, indicate extremities for which this applies:
[] Right upper [] Left upper

13B. For each checked extremity, identify the condition causing loss of function, describe loss of effective function and provide specific examples (brief summary):

Identify the condition causing loss of function:
Describe loss of effective function:
Provide specific examples (brief summary):

SECTION XIV - DIAGNOSTIC TESTING

NOTE: Testing listed below is not indicated for every condition. The diagnosis of degenerative arthritis (osteoarthritis) or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, even if in the past, no further imaging studies are required by VA, even if arthritis has worsened.

14A. Have imaging studies been performed in conjunction with this examination?
[NO]

14B. If yes, is degenerative or post-traumatic arthritis documented?
[]

If yes, indicate side:
[]

14C. If yes, provide type of test or procedure, date and results (brief summary):

Type of procedure:
Date:
Results (brief summary):

14D. Are there any other significant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?
[NO]

If yes, provide type of test or procedure, date and results (brief summary):

Type of procedure:
Date:
Results (brief summary):

14E. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed condition(s):

SECTION XV - FUNCTIONAL IMPACT

NOTE: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

15A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting, etc.)?
[YES]

If yes, describe the functional impact of each condition, providing one or more examples:

He is unable to lift more than 25 lbs or work above shoulder height

SECTION XVI – REMARKS

16A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

SECTION XVII – EXAMINER'S CERTIFICATION AND SIGNATURE

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

17A. Examiner's signature:	AKoita PA-C AKoita PA-C (Jun 16, 2022 09:06 CDT)
17B. Examiner's printed name:	ARLINDA K. KOITA, PA-C
17C. Date signed:	8/11/2022
17D. Examiner's phone/fax numbers:	1-877-637-8387 Fax: 1-800-320-3908
17E/F. National Provider Identifier (NPI) and Medical License Number and State:	1609168525 / 15-01448 KS
17G. Examiner's address:	VA-WICHITA KS 3 144 SOUTH HILLSIDE STREET, WICHITA, KS 67211
17H. Examiner's specialty:	Physician Assistant

Department of Veterans Affairs

INTERNAL VETERANS AFFAIRS USE
BACK (THORACOLUMBAR SPINE) CONDITIONS DISABILITY BENEFITS QUESTIONNAIRE

Name of Claimant/Veteran	Claimant/Veteran's Social Security Number	Date of Examination
Barton,Clint	011-25-2006	08-11-2022 T11:30:00

Note to examiner: The Veteran is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

Is this questionnaire being completed in conjunction with VA 21-2507, C&P examination request? ☒ YES ☐ NO

How was the examination completed? (check all that apply)

- ☐ In-person examination
- ☒ Records reviewed
- ☒ Examination via approved video telehealth
- ☐ Other, please specify in comments box:

Comments:

ACCEPTABLE CLINICAL EVIDENCE (ACE)

Indicate the 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 questionnaire and such an examination will likely provide no additional relevant evidence.
- ☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

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
- ☐ VA electronic health record
- ☐ Other, please identify other evidence reviewed:

Evidence comments:

SECTION I - DIAGNOSIS

Note: These are condition(s) for which an evaluation has been requested on the exam request form (Internal VA) or for which the Veteran has requested medical evidence be provided for submission to VA.

1A. List the claimed condition(s) that pertain to this questionnaire:

T3 T4 low back pain

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

1B. Select diagnoses associated with the claimed condition(s) (check all that apply):

☐ The Veteran does not have a current diagnosis associated with any claimed conditions listed above. (Explain your findings and reasons in the remarks section)

☐	Ankylosing spondylitis	ICD Code:	Date of diagnosis:
☐	Degenerative arthritis	ICD Code:	Date of diagnosis:
☒	Lumbosacral strain	ICD Code: S39.012A	Date of diagnosis: 12.13.2021
☐	Degenerative disc disease other than intervertebral disc syndrome (IVDS)	ICD Code:	Date of diagnosis:
☐	Lumbosacral strain	ICD Code:	Date of diagnosis:
☐	Intervertebral disc syndrome (Note: See VA definition of IVDS in Section XI.)	ICD Code:	Date of diagnosis:
☐	Sacroiliac injury	ICD Code:	Date of diagnosis:
☐	Sacroiliac weakness	ICD Code:	Date of diagnosis:
☐	Segmental instability	ICD Code:	Date of diagnosis:
☐	Spinal fusion	ICD Code:	Date of diagnosis:
☐	Spinal stenosis	ICD Code:	Date of diagnosis:
☐	Spondylolisthesis	ICD Code:	Date of diagnosis:
☐	Traumatic paralysis, complete	ICD Code:	Date of diagnosis:
☐	Vertebral dislocation	ICD Code:	Date of diagnosis:
☐	Vertebral fracture	ICD Code:	
	Other (specify) _____	ICD Code: ____	Date of diagnosis: _____
	Other diagnosis #1: _____	ICD Code: _____	Date of diagnosis: _____
	Other diagnosis #2:	ICD Code:	Date of diagnosis:

SECTION II – MEDICAL HISTORY

2A. Describe the history (including onset and course) of the Veteran's thoracolumbar spine condition (brief summary):

The claimant reports this condition began in 2005

The claimant describes the condition started as a result of physical training exercises, heavy lifting and rucking with heavy weights on back.

The claimant reports symptoms at time of onset as moderate back pain and tightness.

The claimant reports treatment included: back stretches and Ibuprofen

Current Symptoms: increased back pain

Current Treatment: Ibuprofen, Tylenol

2B. Does the Veteran report flare-ups of the thoracolumbar spine?

☒ Yes ☐ No

If yes, document the Veteran's description of the flare-ups he/she experiences, including the frequency, duration, characteristics, precipitating and alleviating factors, severity, and/or extent of functional impairment he/she experiences during a flare-up of symptoms:

Flare-ups of the back occur daily The back flare-ups are severe The back flare-ups last hours The back flare-ups are precipitated by any activity , bending, lifting The back flare-ups are alleviated by rest , medication , stretching The extent of functional impairment due to flare-ups of the back is discussed in section 3D.

SECTION II – MEDICAL HISTORY

2C. Does the Veteran report having any functional loss or functional impairment of the joint or extremity being evaluated on this questionnaire, including but not limited to after repeated use over time?

☒ Yes ☐ No

If yes, document the Veteran's description of functional loss or functional impairment in his/her own words:

Limited range of motion , difficulty with lifting and prolonged activity

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATION

There are several separate parameters requested for describing function of a joint. The question "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 repetitive use over time or during a flare-up; however, this is not always feasible.

Information regarding joint function on repetitive use is broken up into two subsets. The first subset is based on observed repetitive use, and the second is based on functional loss associated with repeated use over time. The observed repetitive use section initially asks for objective findings after three or more repetitions of range of motion testing. The second subset 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. This takes into account not only the objective findings noted on the examination, but also the subjective history provided by the claimant, as well as review of the available medical evidence.

Optimally, a description of any additional loss of function should be provided - such as what the degrees of range of motion would be opined to look like after repetitive use over time. However, when this is not feasible, an "as 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 ROM measurements

☐ All Normal ☒ Abnormal or outside of normal range

☐ Unable to test ☐ Not indicated

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

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:

If abnormal, does the range of motion itself contribute to a functional loss? ☐ Yes ☒ No

If yes, please explain:

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATIONS (continued)

Note: For any joint condition, examiners should address pain on both passive and active motion, and on both weight-bearing and nonweight-bearing. If testing cannot be performed or is medically contraindicated (such as it may cause the Veteran severe pain or the risk of further injury), an explanation must be given below. Please note any characteristics of pain observed on examination (such as facial expression or wincing on pressure or manipulation).

Can testing be performed? ☐ Yes ☐ No

If no, provide an explanation:

Active Range of Motion (ROM) - Perform active range of motion and provide the ROM values.

Forward flexion endpoint (90 degrees):	30	degrees	Left lateral flexion endpoint (30 degrees):	15	degrees
Extension endpoint (30 degrees):	15	degrees	Right lateral rotation endpoint (30 degrees):	15	degrees
Right lateral flexion endpoint (30 degrees):	15	degrees	Left lateral rotation endpoint (30 degrees):	15	degrees

If noted on examination, which ROM exhibited pain (select all that apply):

☒ Forward flexion ☒ Right lateral flexion ☒ Right lateral rotation

☒ Extension ☒ Left lateral flexion ☒ Left lateral rotation

If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.

Forward flexion:	Degree endpoint (if different than above)	Left lateral flexion:	Degree endpoint (if different than above)
Extension:	Degree endpoint (if different than above)	Right lateral rotation:	Degree endpoint (if different than above)
Right lateral flexion:	Degree endpoint (if different than above)	Left lateral rotation:	Degree endpoint (if different than above)

Passive Range of Motion - Perform passive range of motion and provide the ROM values.

Was passive range of motion testing performed? ☒ Yes ☐ No If not, indicate why passive range of motion testing was not performed:

☐ Medically contraindicated (e.g., it may cause the Veteran severe pain or the risk of further injury). It is not medically advisable to conduct passive range of motion testing because (provide explanation).

☐ Testing not necessary because (provide explanation).

☐ Other (provide explanation).

Explanation:

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATIONS (continued)

Forward flexion endpoint (90 degrees):	degrees	☒ Same as active ROM
Extension endpoint (30 degrees):	degrees	☒ Same as active ROM
Right lateral flexion endpoint (30 degrees):	degrees	☒ Same as active ROM
Left lateral flexion endpoint (30 degrees):	degrees	☒ Same as active ROM
Right lateral rotation endpoint (30 degrees):	degrees	☒ Same as active ROM
Left lateral rotation endpoint (30 degrees):	degrees	☒ Same as active ROM

If noted on examination, which passive ROM exhibited pain (select all that apply):

☒ Forward flexion ☒ Right lateral flexion ☒ Right lateral rotation
☒ Extension ☒ Left lateral flexion ☒ Left lateral rotation

If any limitation of motion is specifically attributable to pain, weakness, fatigability, incoordination, or other; please note the degree(s) in which limitation of motion is specifically attributable to the factors identified and describe.

Forward flexion	Degree endpoint (if different than above)	Left lateral flexion	Degree endpoint (if different than above)
Extension	Degree endpoint (if different than above)	Right lateral rotation	Degree endpoint (if different than above)
Right lateral flexion	Degree endpoint (if different than above)	Left lateral rotation	Degree endpoint (if different than above)

Is there evidence of pain? ☒ Yes ☐ No If yes check all that apply:

☒ Weight-bearing ☐ Nonweight-bearing ☒ Active motion ☒ Passive motion ☐ On rest/non-movement

☒ Causes functional loss (if checked describe in the comments box below) ☐ Does not result in/cause functional loss

Comments:
Limited ROM. Difficulty with lifting repetitively over 25 lbs, standing for over 30 minutes and walking over 2 miles due to back pain and stiffness

Is there objective evidence of crepitus? ☐ Yes ☒ No

Is there objective evidence of localized tenderness or pain on palpation of the joint or associated soft tissue? ☐ Yes ☒ No

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

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATIONS (continued)

3B. Observed repetitive use ROM

Is the Veteran able to perform repetitive use testing with at least three repetitions? ☒ Yes ☐ No

If no, please explain:

Is there additional loss of function or range of motion after three repetitions? ☒ Yes ☐ No

If yes, please respond to the following after completion of the three repetitions:

Forward flexion endpoint (90 degrees):	25	degrees	Left lateral flexion endpoint (30 degrees):	15	degrees
Extension endpoint (30 degrees):	15	degrees	Right lateral rotation endpoint (30 degrees):	15	degrees
Right lateral flexion endpoint (30 degrees):	15	degrees	Left lateral rotation endpoint (30 degrees):	15	degrees

Select all factors that cause this functional loss: (check all that apply) ☐ N/A ☒ Pain ☐ Fatigability ☐ Weakness ☒ Lack of endurance ☐ Incoordination ☐ Other:

Note: When pain is associated with movement, the examiner must give a statement on whether pain could significantly limit functional ability during flare-ups and/or after repeated use over time in terms of additional loss of range of motion. In the exam report, the examiner is requested to provide an estimate of decreased range of motion (in degrees) that reflect frequency, duration, and during flare-ups - even if not directly observed during a flare-up and/or after repeated use over time.

3C. Repeated use over time

Is the Veteran being examined immediately after repeated use over time? ☐ Yes ☒ No

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with repeated use over time? ☒ Yes ☐ No

Select all factors that cause this functional loss: (check all that apply) ☐ N/A ☒ Pain ☐ Fatigability ☐ Weakness ☒ Lack of endurance ☐ Incoordination ☐ Other:

Estimate range of motion in degrees for this joint immediately after repeated use over time based on information procured from relevant sources including the lay statements of the Veteran:

Forward flexion endpoint (90 degrees):	20	degrees	Left lateral flexion endpoint (30 degrees):	10	degrees
Extension endpoint (30 degrees):	10	degrees	Right lateral rotation endpoint (30 degrees):	10	degrees
Right lateral flexion endpoint (30 degrees):	10	degrees	Left lateral rotation endpoint (30 degrees):	10	degrees

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence):

3D. Flare-ups

Is the Veteran being examined during a flare-up? ☐ Yes ☒ No

Does procured evidence (statements from the Veteran) suggest pain, fatigability, weakness, lack of endurance, or incoordination which significantly limits functional ability with flare-ups? ☒ Yes ☐ No

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATIONS (continued)

Select all factors that cause this functional loss: (check all that apply) ☐ N/A ☒ Pain ☐ Fatigability ☐ Weakness ☒ Lack of endurance ☐ Incoordination ☐ Other:

Estimate range of motion in degrees for this joint during flare-ups based on information procured from relevant sources including the lay statements of the Veteran:

Forward flexion endpoint (90 degrees):	15	degrees	Left lateral flexion endpoint (30 degrees):	5	degrees
Extension endpoint (30 degrees):	5	degrees	Right lateral rotation endpoint (30 degrees):	5	degrees
Right lateral flexion endpoint (30 degrees):	5	degrees	Left lateral rotation endpoint (30 degrees):	5	degrees

The examiner should provide the estimated range of motion based on a review of all procurable information - to include the Veteran's statement on examination, case-specific evidence (to include medical treatment records when applicable and lay evidence), and the examiner's medical expertise. If, after evaluation of the procurable and assembled data, the examiner determines that it is not feasible to provide this estimate, the examiner should explain why an estimate cannot be provided. The explanation should not be based on an examiner's shortcomings or a general aversion to offering an estimate on issues not directly observed.

Please cite and discuss evidence. (Must be specific to the case and based on all procurable evidence):

3E. Guarding and muscle spasm

Does the Veteran have localized tenderness, guarding or muscle spasm of the thoracolumbar spine?

☐ Yes ☒ No

Localized tenderness:

- ☐ None
- ☐ Not resulting in abnormal gait or abnormal spinal contour

Provide description and/or etiology:

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:

SECTION III - RANGE OF MOTION (ROM) AND FUNCTIONAL LIMITATIONS (continued)

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	☐ Interference with sitting	☐ Interference with standing	☐ Swelling	☐ Deformity
☐ Disturbance of locomotion	☐ Less movement than normal	☐ More movement than normal	☐ Weakened movement	☐ Atrophy of disuse
☐ Instability of station	☐ 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

Side	Flexion/ Extension	Rate Strength	Flexion/ Extension	Rate Strength	Side	Flexion/ Extension	Rate Strength	Flexion/ Extension	Rate Strength
Right	Hip Flexion	5/5	Ankle Dorsiflexion	5/5	Left	Hip Flexion	5/5	Ankle Dorsiflexion	5/5
	Knee Extension	5/5	Great Toe Extension	5/5		Knee Extension	5/5	Great Toe Extension	5/5
	Ankle Plantar Flexion	5/5				Ankle Plantar Flexion	5/5		

4B. Does the Veteran have muscle atrophy?

☐ Yes ☒ No

SECTION IV- MUSCLE STRENGTH TESTING (continued)

4C. If yes, is the muscle atrophy due to the claimed condition in the diagnosis section?

☐ Yes ☐ No

If no, provide rationale:

4D. For any muscle atrophy due to a diagnosis listed in Section I, indicate specific location of atrophy, providing measurements in centimeters of normal side and corresponding atrophied side, measured at maximum muscle bulk.

Provide measurements in centimeters of normal side and atrophied side, measured at maximum muscle bulk.

Circumference of normal side: cm Circumference of atrophied side: cm

SECTION V - REFLEX EXAM

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

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

Right:	Knee: 2 +	Ankle: 2 +
Left:	Knee: 2 +	Ankle: 2 +

SECTION VI - SENSORY EXAM

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

Side	Upper Anterior Thigh (L2)	Thigh/Knee (L3/4)	Lower Leg/Ankle (L4/L5/S1)	Foot/Toes (L5)
Right	☒ Normal ☐ Decreased ☐ Absent	☒ Normal ☐ Decreased ☐ Absent	☒ Normal ☐ Decreased ☐ Absent	☒ Normal ☐ Decreased ☐ Absent
Left	☒ Normal ☐ Decreased ☐ Absent	☒ Normal ☐ Decreased ☐ Absent	☒ Normal ☐ Decreased ☐ Absent	☒ Normal ☐ Decreased ☐ Absent

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.

7A. Provide straight leg raising test results:

Right:	☐ Negative	☒ Positive	☐ Unable to perform
Left:	☐ Negative	☒ Positive	☐ Unable to perform

If "Unable to perform," please explain:

SECTION VIII - RADICULOPATHY

Note: 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. Electromyography (EMG) studies are rarely required to diagnose radiculopathy in the appropriate clinical setting.

Does the Veteran have radicular pain or any other signs or symptoms due to radiculopathy?

☐ Yes ☒ No If yes, complete sections 8A - 8D.

8A. Indicate symptoms' location and severity (check all that apply):

Note: For VA purposes, when the involvement is wholly sensory, the evaluation should be for the mild, or at the most, the moderate degree.

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

SECTION VIII – RADICULOPATHY (continued)

8D. For any abnormal or positive identified neurological findings identified in Sections 4-8, explain the likely cause of those identified symptoms:

SECTION IX - ANKYLOSIS

Note: For VA compensation purposes, unfavorable ankylosis is a condition in which the entire cervical spine, the entire thoracolumbar spine, or the entire spine is fixed in flexion or extension, and the ankylosis results in one or more of the following: difficulty walking because of a limited line of vision; restricted opening of the mouth and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms due to pressure of the costal margin on the abdomen; dyspnea or dysphagia; atlantoaxial or cervical subluxation or dislocation; or neurologic symptoms due to nerve root stretching. Fixation of a spinal segment in neutral position (zero degrees) always represents favorable ankylosis.

9A. Is there ankylosis of the spine?

☐ Yes ☒ No If yes, indicate severity of ankylosis:

☐ Unfavorable ankylosis of the entire spine ☐ Unfavorable ankylosis of the entire thoracolumbar spine ☐ Favorable ankylosis of the entire thoracolumbar spine

9B. Comments, if any:

SECTION X - OTHER NEUROLOGIC ABNORMALITIES

10A. Does the Veteran have any other neurologic abnormalities or findings (other than those identified in Sections 4 - 8) related to a thoracolumbar spine condition (such as bowel or bladder problems/pathologic reflexes)?

☐ 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 disc herniation with compression and/or irritation of the adjacent nerve root 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. Imaging studies are not required to make the diagnosis of IVDS.

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

SECTION XI - INTERVERTEBRAL DISC SYNDROME (IVDS) AND EPISODES REQUIRING BED REST (continued)

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	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Crutches	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant
☐ Cane	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 condition, indicate the side, and identify the assistive device used for each condition.

SECTION XIII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

Note: The intention of this section is to permit the examiner to quantify the level of remaining function; it is not intended to inquire whether the Veteran should undergo an amputation with fitting of a prosthesis. For example, if the functions of grasping (hand) or propulsion (foot) are as limited as if the Veteran had an amputation and prosthesis, the examiner should check yes and describe the diminished functioning. The question simply asks whether the functional loss is to the same degree as if there were an amputation of the affected limb.

13A. Due to the Veteran's thoracolumbar spine 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 ☐ Right upper ☐ Left upper

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 or other disfigurement of the skin related to any conditions or to the treatment of any conditions listed in the diagnosis section?

☐ Yes ☒ No

If yes, complete appropriate dermatological questionnaire.

14C. Comments, if any:

SECTION XV - DIAGNOSTIC TESTING

Note: Testing listed below is not indicated for every condition. The diagnosis of degenerative arthritis (osteoarthritis) or post-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.

15A. Have imaging studies been performed in conjunction with this examination?

☒ Yes ☐ No

15B. If yes, is degenerative or post-traumatic arthritis documented?

☒ Yes ☐ No

15C. If yes, provide type of test or procedure, date and results (brief summary):

X Ray 12/13/2021

Thoracic spine: WNL

Lumbar spine: Mild to moderate degenerative disc disease at L5-S1

15D. Does the Veteran have imaging evidence of a thoracic vertebral fracture with loss of 50 percent or more of height?

☐ Yes ☒ No ☐ N/A

15E. Are there any other significant diagnostic test findings or results related to the claimed condition(s) and/or diagnosis(es), that were reviewed in conjunction with this examination?

☐ Yes ☒ No

If yes, provide type of test or procedure, date and results (brief summary):

15F. If any test results are other than normal, indicate relationship of abnormal findings to diagnosed conditions:

Direct relation

SECTION XVI - FUNCTIONAL IMPACT

Note: Provide the impact of only the diagnosed condition(s), without consideration of the impact of other medical conditions or factors, such as age.

16A. Regardless of the Veteran's current employment status, do the conditions listed in the diagnosis section impact his/her ability to perform any type of occupational task (such as standing, walking, lifting, sitting etc.)?

☒ Yes ☐ No

If yes, describe the functional impact of each condition, providing one or more examples:

Limited ROM. Difficulty with lifting repetitively over 25 lbs, standing for over 30 minutes and walking over 1 mile due to back pain and stiffness

SECTION XVII - REMARKS

17A. Remarks (if any – please identify the section to which the remark pertains when appropriate).

A goniometer was used for all joint range of motion measurements. For the claimant's claimed condition of low back pain please refer to the diagnosis section.
The suicide risk level is not at elevated acute risk.

SECTION XVIII - EXAMINER'S CERTIFICATION AND SIGNATURE

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

18A. Examiner's signature	18B. Examiner's printed name	18C. Date signed
Sonya Dewey, APRN, FNP-C 20614102-11d2-4d47-b805-a66caa653d05	DEWEY SONYA FNP-C NURSE PRACTITIONER	8/11/2022 (UTC)

18D. Examiner's phone number	18E. National Provider Identifier (NPI) number	18F. Medical license number and state number
2547680468 2542671077	1275004855	AP137634 TX

18G. Examiner's address
581 PAN AMERICAN DR SUITE 1 HARKER HEIGHTS TX 76548

Department of Veterans Affairs

SINUSITIS/RHINITIS AND OTHER CONDITIONS OF THE NOSE, THROAT, LARYNX AND PHARYNX DISABILITY BENEFITS QUESTIONNAIRE

IMPORTANT – THE DEPARTMENT OF VETERANS AFFAIRS (VA) ***WILL NOT PAY OR REIMBURSE*** ANY EXPENSES OR COST INCURRED IN THE PROCESS OF COMPLETING AND/OR SUBMITTING THIS FORM. PLEASE READ THE PRIVACY ACT AND RESPONDENT BURDEN INFORMATION BEFORE COMPLETING FORM.

NAME OF PATIENT/VETERAN	PATIENT/VETERAN'S SOCIAL SECURITY NUMBER
Barton,Clint	011-25-2006

NOTE TO PHYSICIAN - Your patient is applying to the U.S. Department of Veterans Affairs (VA) for disability benefits. VA will consider the information you provide on this questionnaire as part of their evaluation in processing the Veteran's claim.

Is this questionnaire being completed in conjunction with a VA 21-2507, C&P examination request? ☒ Yes ☐ No

How was the examination completed? Check all that apply:

- ☒ In-person examination
- ☒ Records reviewed
- ☐ Examination via approved telehealth
- ☐ Other, please specify in comments box:

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 questionnaire and such an examination will likely provide no additional relevant evidence.

☐ Review of available records in conjunction with an interview with the Veteran (without in-person or telehealth examination) using the ACE process because the existing medical evidence supplemented with an interview provided sufficient information on which to prepare the questionnaire and such an examination would likely provide no additional relevant evidence.

EVIDENCE REVIEW

EVIDENCE REVIEWED *(check all that apply):*

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

EVIDENCE COMMENTS:
Branch(es) of Service Entry on Duty Release Active Duty Era(s) of Service
Army
June 06, 1995
June 06, 2018
Gulf War

problem list page 76

A/P Written by LOWE,PAUL W
17 Aug 2015 1138 CDT
1. Other lesions of oral mucosa K13.79
Medication(s): -CHLORHEXIDINE-(PERIOGARD)-0.12% ORAL SOL - RINSE AND SPIT WITH ONE TABLESPOONFUL (15ML) OF SOLUTION FOR 30 SECONDS TWICE EVERY DAY #1 RFO
-SC MENTHOL/BENZ-(CEPACOL)□MTH LOZG - DISSOLVE 1 LOZENGE ORALLY PER PACKAGE INSTRUCTIONS #16 RFO
2. Unspecified contact dermatitis due to plants, except food L25.5
Medication(s): -HYDROCORTISONE-(CORTAID)-1% TOP CREAM - APPLY TO AFFECTED AREA 2 TO 3 TIMES EVERY DAY FOR RASH #30 RFO
-MENTHOL/CAMPHOR-(SARNA)-0.5/0.5% TOP LOT - APPLY TO AFFECTED AREA 2 OR 3 TIMES EVERY DAY AS NEEDED FOR ITCHING #222 RFO

A/P Last Updated by DENKEWALTER.MICHAEL T a 25 Sep 2016 1236 ADT
1. Deviated nasal septum

Plan/Comment(s):
- SM with deviated septum on exam, interfering with exercise, sleep, normal breathing. Due to noted
deformity, he is referred to ENT for further evaluation and discussion of potential tx options.
Flonase prescribed at this time, initial imagery ordered.
Pt counseled on diagnosis, treatment, medication use and side effects, and behavioral modification(s). Pt
advised of f/u instructions and ED criteria. Pt expressed agreement with treatment plan; all questions and concerns were addressed.
Medication(s):
- Medication: FLUTICASONE PROP 50 MCG NAS SPSN [16GM]; SIG: USE 2 SPRAYS IN EACH
NOSTRIL EVERY DAY (MAY DECREASE TO 1 SPRAY EACH NOSTRIL AFTER 1 WEEK) #2 RF2

11/2020 septoplasty
REQUEST FOR ADMINISTRATION OF ANESTHESIA
MEDICAL RECORD AND FOR PERFORMANCE OF OPERATIONS AND OTHER PROCEDURES

Chief Comolaint
Problem List/Past Medical History
postop
Ongoing
Assessment/Plan
Acquired nasal deformity
1. Postoperative visit
Historical
21 yo Mwith acquired nasla deformity and nasal obstruction now s/p septorhinoplasty with
Atrial fibrillation
osteotomies and inferior turbinoplasty on 25N0V2010. Here for first postop visit.
Procedure/Surgical History
Thermasplint, doyles, and sutures removed. Looks very good, straight.
with no perforation. Turbinates well reduced. Pt satisfied with cosmetic and functional
Cardioversion a-fib (2010)
outcome. Advised to use saline irrigations twice a day indefinitely, and to use mupirocin for
Transesophageal echocardiography
1 more week. F/u in 4-6 weeks.
for congenital cardiac anomalies;
image acquisition, interpretation and
Wes Mcllwain, MD
report only (2010)

Basic Information
Problem List/Past Medical History
Time Seen:
Ongoing
PETTY, NORMAN 02/19/2011 13:31
No qualifying data
Historical
history of AFIB, cardioverted 3 months ago at porter heart center, stopped blood thinners 2 Acquired nasal deformity
Chief ComDlaint
Atrial fibrillation
months ago, COVID 3 months ago
History of Present Illness
Procedure/Surgical History
Approximately one hour prior to arrival patient got some chest pain, Irregular heartbeat. The irregular heartbeat laste
d about 30 minutes.
It now feels like its almost
Cardioversion a-fib (2010)
normal, however he still has chest pain. He states she has had atrial fibrillation, and it
Transesophageal echocardiography
appears every time he eats a food called 'toronados"

A/P Written by JON ES.JASON A 0 01 Oct 2010 0850 ADT
1. Unspecified atrial fibrillation 148.91
Plan/Comment(s):
- Spoke on the phone with Dr. Petty regarding 21 yo M with atrial fibrillation/flutter with RVR and
symptomatic palpitations following ingestion of pre workout supplement and fat burner supplement. Patient
rate controlled with IV diltiazem, but with persistent atrial fibrillation/flutter. This is provoked rhythm in an otherwise young healthy male without known cardiac disease. The primary treatment is abstinence from
offending agents. He requires echocardiogram to exclude undiagnosed structural disease and
telemetry/Holter monitor to assess resolution vs continued rhythm. Neither of these services are available at
BACH. Recommend starting oral rate controlling agent such as diltiazem or metoprolol. Recommend primary care physician follow up and cardiology consultation to discussed provoked arrhythmia, reassess EKG, and
to discuss continuing/discontinuing nodal blockade, as well as discussion of stroke risk.

6/22/21 denkewalter
Echo on
due until 06/21/23 and every 1 years

7 Oct was non-concerning, pt was placed on Coichicine and Xarelto, both discontinued by
Adult
- Body Mass Index not due
Porter Heart Nov 2010. 2x 7-day Holters (Oct 2010 & Feb 2011) non-concerning for
until 06/21/12 and every 1 years
malignant arrhythmias. Pt with ER visit on 19 Feb 2011, concerned regarding return of
Adult
- Depression Screening not due
A-fib, not indicated by exam/EKG at that time. Pt underwent EST on 7 Apr 2011, Porter
until 06/21/12 and every 1 years
Heart indicated pt is likely RTD at that time

The following Sf0 Note Was Overwritten by CONGDON. TIMOTHY SCOTT 0, 09 Oct 2008 0756 CDT
S/O Note Written by CLAYTON,DENISE c51 09 Oct 2008 0735 CDT
Chief complaint
The Chief Complaint is F/u.
History of present illness

Note accomplished in TSWF-CORE'>
SM is here for a f/u from past encounter at CTMC. SM was seen in CTMC on 27 sep 18 for Lt ankle sprain. SM states that he is not experiencing any pain at this time and feels much better. SM states that he is taking all medications as directed. SM states that he would like an RTD.

enl 2018 neg

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH A SINUS, NOSE, THROAT, LARYNX OR PHARYNX CONDITION? *(This is the condition the Veteran is claiming or for which an exam has been requested.)*

☒ YES ☐ NO

1B. IF YES, SELECT THE VETERAN'S CONDITION *(check all that apply)*

☐ CHRONIC SINUSITIS	ICD CODE:	DATE OF DIAGNOSIS:
☐ ALLERGIC RHINITIS	ICD CODE:	DATE OF DIAGNOSIS:
☐ NON-ALLERGIC RHINITIS	ICD CODE:	DATE OF DIAGNOSIS:
☐ BACTERIAL RHINITIS	ICD CODE:	DATE OF DIAGNOSIS:
☐ GRANULOMATOUS RHINITIS	ICD CODE:	DATE OF DIAGNOSIS:
☐ CHRONIC LARYNGITIS	ICD CODE:	DATE OF DIAGNOSIS:
☐ LARYNGECTOMY	ICD CODE:	DATE OF DIAGNOSIS:
☐ LARYNGEAL STENOSIS	ICD CODE:	DATE OF DIAGNOSIS:
☐ APHONIA	ICD CODE:	DATE OF DIAGNOSIS:
☐ PHARYNGEAL INJURY *(Describe):*	ICD CODE:	DATE OF DIAGNOSIS:
☒ DEVIATED NASAL SEPTUM *(Traumatic)*	ICD CODE: J34.2	DATE OF DIAGNOSIS: 8/11/22
☐ ANATOMICAL LOSS OF PART OF NOSE *(Complete Scar Benefits Questionnaire in lieu of this questionnaire)*	ICD CODE:	DATE OF DIAGNOSIS:
☐ BENIGN OR MALIGNANT NEOPLASM OF SINUS, NOSE, THROAT, LARYNX OR PHARYNX	ICD CODE:	DATE OF DIAGNOSIS:
☐ Other *(specify):*		
OTHER DIAGNOSIS #1:	ICD CODE: j34	DATE OF DIAGNOSIS:
OTHER DIAGNOSIS #2:	ICD CODE:	DATE OF DIAGNOSIS:

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO THE SINUSES, NOSE, THROAT, LARYNX, OR PHARYNX CONDITION(S), LIST USING ABOVE FORMAT:

SECTION II – MEDICAL HISTORY

2. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S SINUS, NOSE, THROAT, LARYNX, OR PHARYNX CONDITION:

broken nose, in Ft.Riley , in service around 2011-2012, Currently when running or exercise cannot breath through my nose, feels clogged up all the time, sense of smell sinc e then, can smell strong things, such as hand sanitizer

SECTION III – NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS

3. DOES THE VETERAN HAVE ANY OF THE FOLLOWING NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS?

☒ YES ☐ NO *(If "No," proceed to Section IV) (If "Yes," check all that apply):*

- ☐ Sinusitis *(If checked, complete Part A below)*
- ☐ Rhinitis *(If checked, complete Part B below)*
- ☐ Larynx or pharynx condition *(If checked, complete Part C below)*
- ☒ Deviated nasal septum *(traumatic)* *(If checked, complete Part D below)*
- ☐ Tumors or neoplasms *(If checked, complete Part E below)*
- ☐ Other nose, throat, larynx or pharynx conditions, pertinent physical findings or scars due to nose, throat, larynx or pharynx conditions. *(If checked, complete Part F below)*

PART A - SINUSITIS

A1. INDICATE THE SINUSES/TYPE OF SINUSITIS CURRENTLY AFFECTED BY THE VETERAN'S CHRONIC SINUSITIS (*Check all that apply*):

☐ NONE ☐ MAXILLARY ☐ FRONTAL ☐ ETHMOID ☐ SPHENOID ☐ PANSINUSITIS

A2. DOES THE VETERAN CURRENTLY HAVE ANY FINDINGS, SIGNS OR SYMPTOMS ATTRIBUTABLE TO CHRONIC SINUSITIS?

☐ YES ☐ NO

(If "Yes," check all that apply)

- ☐ Chronic sinusitis detected only by imaging studies *(See Diagnostic Testing Section)*
- ☐ Episodes of sinusitis
- ☐ Near constant sinusitis *(If checked, describe frequency)*:
- ☐ Headaches
- ☐ Pain of affected sinus
- ☐ Tenderness of affected sinus
- ☐ Purulent discharge
- ☐ Crusting
- ☐ Other *(describe)*:

FOR ALL CHECKED CONDITIONS, DESCRIBE:

A3. HAS THE VETERAN HAD **NON-INCAPACITATING** EPISODES OF SINUSITIS CHARACTERIZED BY HEADACHES, PAIN AND PURULENT DISCHARGE OR CRUSTING IN THE PAST 12 MONTHS?

☐ YES ☐ NO

(If "Yes," provide the total number of non-incapacitating episodes over the past 12 months):

☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 or more

A4. HAS THE VETERAN HAD I**NCAPACITATING** EPISODES OF SINUSITIS REQUIRING PROLONGED (*4 to 6 weeks*) OF ANTIBIOTICS TREATMENT IN THE PAST 12 MONTHS?

NOTE - For VA purposes, an incapacitating episode of sinusitis means one that requires bed rest and treatment prescribed by a physician.

☐ YES ☐ NO

(If "Yes," provide the total number of incapacitating episodes of sinusitis requiring prolonged (4 to 6 weeks) of antibiotic treatment over the past 12 months):

☐ 1 ☐ 2 ☐ 3 or more

A5. HAS THE VETERAN HAD SINUS SURGERY?

☐ YES ☐ NO

(If "Yes," specify type of surgery):

☐ Radical *(open sinus surgery)* ☐ Endoscopic ☐ Other*:*

(Type of procedure, sinuses operated on and side(s)):

(Date(s) of surgery (if repeated sinus surgery, provide all dates of surgery)):

A6. IF VETERAN HAS HAD RADICAL SINUS SURGERY, DID CHRONIC OSTEOMYELITIS FOLLOW THE SURGERY?

☐ YES ☐ NO *(If "Yes," complete Osteomyelitis Questionnaire)*

A7. HAS THE VETERAN HAD REPEATED SINUS-RELATED SURGICAL PROCEDURES PERFORMED?

☐ YES ☐ NO

PART B - RHINITIS

B1. IS THERE GREATER THAN 50% OBSTRUCTION OF THE NASAL PASSAGE ON BOTH SIDES DUE TO RHINITIS?

☐ YES ☐ NO

B2. IS THERE COMPLETE OBSTRUCTION ON THE LEFT SIDE DUE TO RHINITIS?

☐ YES ☐ NO

B3. IS THERE COMPLETE OBSTRUCTION ON THE RIGHT SIDE DUE TO RHINITIS?

☐ YES ☐ NO

B4. IS THERE PERMANENT HYPERTROPHY OF THE NASAL TURBINATES?

☐ YES ☐ NO

B5. ARE THERE NASAL POLYPS?

☐ YES ☐ NO

SECTION III - NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS *(Continued)*

PART B – RHINITIS *(Continued)*

B6. DOES THE VETERAN HAVE ANY OF THE FOLLOWING GRANULOMATOUS CONDITIONS?

☐ YES ☐ NO *(If "Yes," check all that apply)*

☐ Granulomatous rhinitis ☐ Rhinoscleroma ☐ Wegener's granulomatosis ☐ Lethal midline granuloma

☐ Other granulomatous infection *(Describe):*

PART C - LARYNX AND PHARYNX CONDITIONS

C1. DOES THE VETERAN HAVE CHRONIC LARYNGITIS?

☐ YES ☐ NO

(If "Yes," does the Veteran have any of the following symptoms due to chronic laryngitis?)

☐ YES ☐ NO *(If "Yes," check all that apply)*

☐ Hoarseness *(If checked, describe frequency):*

☐ Inflammation of vocal cords

☐ Inflammation of mucous membrane

☐ Thickening of vocal cords

☐ Nodules of vocal cords

☐ Submucous infiltration of vocal cords

☐ Vocal cord polyps

☐ Other *(describe):*

C2. HAS THE VETERAN HAD A LARYNGECTOMY?

☐ YES ☐ NO *(If "Yes," specify)*

☐ Total laryngectomy

☐ Partial laryngectomy

(If checked, does the veteran have any residuals of the partial laryngectomy?)

☐ YES ☐ NO

(If "Yes," describe):

C3. DOES THE VETERAN HAVE LARYNGEAL STENOSIS, INCLUDING RESIDUALS OF LARYNGEAL TRAUMA (*unilateral or bilateral*)?

☐ YES ☐ NO *(If "Yes," assess for upper airway obstruction with pulmonary function testing to include Flow-Volume Loop, and provide results in Diagnostic Testing Section)*

C4. DOES THE VETERAN HAVE COMPLETE ORGANIC APHONIA?

☐ YES ☐ NO *(If "Yes," check all that apply)*

☐ Constant inability to speak above a whisper

☐ Constant inability to communicate by speech

☐ Other *(describe):*

C5. DOES THE VETERAN HAVE INCOMPLETE ORGANIC APHONIA?

☐ YES ☐ NO *(If "Yes," check all that apply)*

☐ Hoarseness *(If checked, describe frequency):*

☐ Inflammation of vocal cords

☐ Inflammation of mucous membrane

☐ Thickening of vocal cords

☐ Nodules of vocal cords

☐ Submucous infiltration of vocal cords

☐ Vocal cord polyps

☐ Other *(describe):*

C6. HAS THE VETERAN HAD A PERMANENT TRACHEOSTOMY?

☐ YES ☐ NO *(If "Yes," describe reason for tracheostomy and potential for decannulation):*

SECTION III - NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS *(Continued)*

PART C - LARYNX AND PHARYNX CONDITIONS

C7. HAS THE VETERAN HAD AN INJURY TO THE PHARYNX?

☐ YES ☐ NO *(If "Yes," check all findings, signs and symptoms that apply):*

- ☐ Obstruction of the pharynx
- ☐ Obstruction of the nasopharynx
- ☐ Stricture of the pharynx
- ☐ Stricture of the nasopharynx
- ☐ Absence of the soft palate secondary to trauma
- ☐ Absence of the soft palate secondary to chemical burn
- ☐ Absence of the soft palate secondary to granulomatous disease
- ☐ Paralysis of the soft palate
- ☐ Swallowing difficulty
- ☐ Nasal regurgitation
- ☐ Speech impairment
- ☐ Other *(describe):*

C8. DOES THE VETERAN HAVE VOCAL CORD PARALYSIS OR ANY OTHER PHARYNGEAL OR LARYNGEAL CONDITIONS?

☐ YES ☐ NO *(If "Yes," describe):*

PART D - DEVIATED NASAL SEPTUM *(TRAUMATIC)*

D1. IS THERE AT LEAST 50% OBSTRUCTION OF THE NASAL PASSAGE ON BOTH SIDES DUE TO TRAUMATIC SEPTAL DEVIATION?

☒ YES ☐ NO

D2. IS THE VETERAN'S DEVIATED SEPTUM TRAUMATIC?

☒ YES ☐ NO

D3. IS THERE COMPLETE OBSTRUCTION ON LEFT SIDE DUE TO TRAUMATIC SEPTAL DEVIATION?

☐ YES ☒ NO

D4. IS THERE COMPLETE OBSTRUCTION ON RIGHT SIDE DUE TO TRAUMATIC SEPTAL DEVIATION?

☐ YES ☒ NO

PART E - TUMORS AND NEOPLASMS

E1. DOES THE VETERAN HAVE A BENIGN OR MALIGNANT NEOPLASM OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO *(If "Yes," complete the following section)*

E2. IS THE NEOPLASM:

☐ BENIGN ☐ MALIGNANT

E3. HAS THE VETERAN COMPLETED TREATMENT OR IS THE VETERAN CURRENTLY UNDERGOING TREATMENT FOR A BENIGN OR MALIGNANT NEOPLASM OR METASTASES?

☐ YES ☐ NO; WATCHFUL WAITING

(If "Yes," indicate type of treatment the Veteran is currently undergoing or has completed (check all that apply)):

☐ Treatment completed; currently in watchful waiting status

☐ Surgery *(If checked, describe):* (Date(s) of surgery):

☐ Radiation therapy

(Date of most recent treatment): *(Date of completion of treatment or anticipated date of completion):*

☐ Antineoplastic chemotherapy

(Date of most recent treatment): *(Date of completion of treatment or anticipated date of completion):*

☐ Other therapeutic procedure *(If checked, describe procedure):*

(Date of most recent procedure):

☐ Other therapeutic treatment *(If checked, describe treatment):*

(Date of completion of treatment or anticipated date of completion):

E4. DOES THE VETERAN CURRENTLY HAVE ANY RESIDUAL CONDITIONS OR COMPLICATIONS DUE TO THE NEOPLASM (*including metastases*) OR ITS TREATMENT, OTHER THAN THOSE ALREADY DOCUMENTED IN THE REPORT ABOVE?

☐ YES ☐ NO *(If "Yes," list residual conditions and complications (brief summary)):*

SECTION III - NOSE, THROAT, LARYNX OR PHARYNX CONDITIONS *(Continued)*

PART E - TUMORS AND NEOPLASMS *(Continued)*

E5. IF THERE ARE ADDITIONAL BENIGN OR MALIGNANT NEOPLASMS OR METASTASES RELATED TO ANY OF THE DIAGNOSES IN THE DIAGNOSIS SECTION, DESCRIBE USING THE ABOVE FORMAT:

PART F - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS, SYMPTOMS, AND SCARS

F1. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS OR SYMPTOMS RELATED TO THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION ABOVE?

☒ YES ☐ NO

IF YES, DESCRIBE *(brief summary)*:

hypertrophy of nasal turbinates

nose is deformed

F2. 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.

F3. COMMENTS, IF ANY:

F4. DOES THE VETERAN HAVE LOSS OF PART OF THE NOSE OR OTHER SCARS OF THE NOSE EXPOSING BOTH NASAL PASSAGES?

☐ YES ☒ NO

F5. DOES THE VETERAN HAVE LOSS OF PART OF THE NOSE OR OTHER SCARS CAUSING LOSS OF PART OF ONE ALA?

☐ YES ☒ NO

F6. DOES THE VETERAN HAVE LOSS OF PART OF THE NOSE OR OTHER SCARS CAUSING ANY OTHER DISFIGUREMENT?

☐ YES ☒ NO

SECTION IV – DIAGNOSTIC TESTING

NOTE: If testing has been performed and reflects the Veteran's current condition, repeat testing is not required. Specific diagnostic testing is not required for many conditions, but if performed, record in this section.

4A. HAVE IMAGING STUDIES OF THE SINUSES OR OTHER AREAS BEEN PERFORMED?

☒ YES ☐ NO

(If "Yes," check all that apply)

☐ Magnetic resonance imaging *(MRI)*	Date:	Results:
☐ Computed tomography *(CT)*	Date:	Results:
☒ X-rays: nasal bone	Date: 2/83/22	Results: no acute fracture
☐ Other:	Date:	Results:

4B. HAS ENDOSCOPY BEEN PERFORMED?

☐ YES ☒ NO

(If "Yes," check all that apply)

☐ Nasal endoscopy	Date:	Results:
☐ Laryngeal endoscopy	Date:	Results:
☐ Bronchoscopy	Date:	Results:
☐ Other endoscopy	Date:	Results:

4C. HAS THE VETERAN HAD A BIOPSY OF THE LARYNX OR PHARYNX?

☐ YES ☒ NO

(If "Yes," complete the following):

Site of biopsy: Date:

Results: ☐ Benign ☐ Pre-malignant ☐ Malignant

Describe results:

4D. HAS THE VETERAN HAD PULMONARY FUNCTION TESTING TO ASSESS FOR UPPER AIRWAY OBSTRUCTION DUE TO LARYNGEAL STENOSIS?

☐ YES ☒ NO

If "Yes," indicate results:

☐ FEV-1 of 71 to 80% predicted

☐ FEV-1 of 56 to 70% predicted

☐ FEV-1 of 40 to 55% predicted

☐ FEV-1 less than 40% predicted

Is the Flow-Volume Loop compatible with upper airway obstruction?

☐ YES ☐ NO

4E. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDINGS AND/OR RESULTS?

☐ YES ☒ NO *(If "Yes," provide type of test or procedure, date and results (brief summary)):*

SECTION V – FUNCTIONAL IMPACT AND REMARKS

5A. DOES THE VETERAN'S SINUS, NOSE, THROAT, LARYNX OR PHARYNX CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☒ NO *(If "Yes," describe impact of each of the veteran's sinus, nose, throat, larynx or pharynx conditions, providing one or more examples):*

5B. REMARKS *(If any)*

For the claimant's claimed condition of hypertrophy of nasal turbinates please refer to the diagnosis section. For the claimant's claimed condition of acquired deformity of nose (broken) please refer to the diagnosis section. For the claimant's claimed condition of deviated nasal septum please refer to the diagnosis section.

The suicide risk level is not at elevated acute risk.

NOTE: VA may request additional medical information, including additional examinations if necessary to complete VA's review of the application.

SECTION VII – PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

7A. PHYSICIAN'S SIGNATURE	7B. PHYSICIAN'S PRINTED NAME	7C. DATE SIGNED
sue wiechelman b2343011-4fc0-4ffc-be81-ec6142bc3256	WIECHELMAN SUSAN M CNP NURSE PRACTITIONER	08/11/2022 (UTC)

7D. PHYSICIAN'S PHONE AND FAX NUMBERS	7E. NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER	7F. PHYSICIAN'S ADDRESS
2166611687 2166611806	NPI#:1396780938 Lic#:APRN.CNP.07424 OH	4269 Pearl Rd Ste 102 SUITE 102 NEW YORK NY 10015

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.

OMB Control No. 2900-0826
Respondent Burden: 15 minutes
Expiration Date: 08/31/2021

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INTENT TO FILE A CLAIM FOR COMPENSATION AND/OR PENSION, OR SURVIVORS PENSION AND/OR DIC

(This Form Is Used to Notify VA of Your Intent to File for the General Benefit(s) Checked Below)

Note: Please read the Privacy Act and Respondent Burden below before completing the form.

SECTION I: CLAIMANT/VETERAN IDENTIFICATION

NOTE: You can ***either*** complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly to expedite processing of the form.

1. CLAIMANT'S NAME *(First, middle initial, last)*
Clint D Barton

2. CLAIMANT'S SOCIAL SECURITY NUMBER	3. VA FILE NUMBER	4. VETERAN'S DATE OF BIRTH (MM,DD,YYYY)
011-25-2006		**01-11-1977**

5. VETERAN'S NAME *(First, middle initial, last)* ***(If different from claimant)***
Clint D Barton

6. VETERAN'S SOCIAL SECURITY NUMBER	7. VETERAN'S SEX	8. VETERAN'S SERVICE NUMBER (If applicable)
011-25-2006	☑ MALE ☐ FEMALE	

9. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street **890 fifth avenue**

Apt./Unit Number

City **New York**

State/Province **NY** Country **US** ZIP Code/Postal Code **10001**

10. HAS THE VETERAN EVER FILED A CLAIM WITH VA?	11. TELEPHONE NUMBER *(Include Area Code)*	12. E-MAIL ADDRESS *(If applicable)*
☑ YES ☐ NO	**3368675309**	**Hawkeye2022@gmail.com**

SECTION II: GENERAL BENEFIT ELECTION

IMPORTANT: *VA may not be able to use this form to establish an effective date for benefits if you* ***do not*** *select one or more of the general benefits listed below.*

13. I intend to file for the general benefit(s) checked below: *(Choose all that apply)*

☑ **COMPENSATION** ☐ **PENSION**

NOTE: Only check this box if you are a surviving dependent of the veteran.

☐ **SURVIVORS PENSION AND/OR DEPENDENCY AND INDEMNITY COMPENSATION (DIC)**

IMPORTANT: After receiving this form, VA will give you the appropriate application to file for the general benefit you select above. You can also apply for VA disability compensation online through eBenefits at www.ebenefits.va.gov. If you give VA a completed application for the selected general benefit within ***one*** year of filing this form, your completed application will be considered filed as of the date of receipt of this form. Only the ***first*** completed application for each selected general benefit that is received after you file this form will be considered filed as of the date of receipt of this form. You may indicate your intent to file for more than one general benefit on this form or you may submit a separate intent to file for each general benefit. Please complete as many fields in Section II as possible. VA cannot process this form if we cannot identify the claimant and veteran.

SECTION III: DECLARATION OF INTENT

By filing this form, I hereby indicate my intent to apply for one or more general benefits under the laws administered by VA. I acknowledge that: (1) this is ***not a claim for benefits;*** (2) I must file a complete application for each general benefit with VA before VA will process my claim; and (3) a complete application for the same general benefit(s) as indicated on this form must be received within one year of the date VA receives this form for my application to be considered filed as of the date of this form.

14A. SIGNATURE OF CLAIMANT/AUTHORIZED REPRESENTATIVE	14B. DATE SIGNED *(MM,DD,YYYY)*
Dale Phillips VFW	**06/04/2021**

15. NAME OF ATTORNEY, AGENT, OR VETERANS SERVICE ORGANIZATION *(Please Print)*
(**NOTE:** This form may only be completed by a Veterans Service Organization, attorney, or agent if a valid power of attorney has been completed.)

Veterans of Foreign Wars of the United States

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 benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. Your obligation to respond is required only to preserve a date of claim for an application that is received within one year of receipt of this form. VA uses your Social Security number to identify if you have a claim file and to ensure that your records are properly associated with your claim file. VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by 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 the appropriate application and provide it to the claimant.

RESPONDENT BURDEN: We need this information to determine and to provide the claimant with the appropriate application for VA benefits (38 U.S.C. 5102). 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 this 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.

OMB Control No. 2900-0747
Respondent Burden: 25 minutes
Expiration Date: 09/30/2022

Department of Veterans Affairs

APPLICATION FOR DISABILITY COMPENSATION AND RELATED COMPENSATION BENEFITS

VA DATE STAMP (DO NOT WRITE IN THIS SPACE)

IMPORTANT: Please read the Privacy Act and Respondent Burden on page 12 before completing the form.

1. SELECT THE TYPE OF CLAIM PROGRAM/PROCESS *(Check the appropriate box) (See instruction pages 1-3 for definitions of the Fully Developed Claim (FDC) Program (Optional Expedited Process) or the Standard Claim Process. (See instruction page 5 for the definition of a Benefits Delivery at Discharge (BDD) Program Claim)*

- [x] FULLY DEVELOPED CLAIM (FDC) PROGRAM
- [ ] STANDARD CLAIM PROCESS
- [ ] IDES (Select this option ***only*** if you have been referred to the IDES Program by your Military Service Department)
- [ ] BDD Program Claim (Select this option ***only*** if you meet the criteria for the BDD Program specified on Instruction Page 5)

NOTE: You may *either* complete the form online or by hand. If completed by hand, print the information requested in ink, neatly, and legibly to expedite processing of the form.

SECTION I: IDENTIFICATION AND CLAIM INFORMATION

2. VETERAN/SERVICE MEMBER NAME *(First, Middle Initial, Last)*
Clint D Barton

3. VETERAN'S SOCIAL SECURITY NUMBER *(SSN)*
011-25-2006

4. HAVE YOU EVER FILED A CLAIM WITH VA? *(If "Yes," provide your file number in Item 5)*
- [ ] YES
- [x] NO

5. VA FILE NUMBER

6. DATE OF BIRTH *(MM,DD,YYYY)*
Month Day Year
01-11-1977

7. VETERANS SERVICE NUMBER *(if applicable)*

8. SEX
- [x] MALE
- [ ] FEMALE

9. BDD CLAIMS ***ONLY*: PROVIDE THE DATE OR ANTICIPATED DATE OF RELEASE FROM ACTIVE DUTY *(MM,DD,YYYY)***
Month Day Year

10. TELEPHONE NUMBER(S) *(Include Area Code)*
Daytime: **3368675309**
Evening:
Cell: **()**

11. CURRENT MAILING ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. & Street **890 fifth avenue**
Apt./Unit Number
City **New York**
State/Province **NY** Country **United States** ZIP Code/Postal Code **10001**

12. E-MAIL ADDRESS *(Optional)*
Hawkeye2022@gmail.com

- [ ] 13. IF YOU ARE CURRENTLY A VA EMPLOYEE, CHECK THE BOX *(Includes Work Study/Internship)? (If you are not a VA employee skip to Section II, if applicable)*

SECTION II: CHANGE OF ADDRESS

NOTE: If you are temporarily or permanently changing your address, complete Items 14A through 14C.

14A. TYPE OF ADDRESS CHANGE *(Complete if applicable) (Check only one box)*
- [ ] TEMPORARY
- [ ] PERMANENT

14B. NEW ADDRESS *(Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)*
No. & Street
Apt./Unit Number
City
State/Province
Country
ZIP Code/Postal Code

14C. EFFECTIVE DATE(S) OF NEW ADDRESS *(If your change of address is **temporary**, complete both the beginning and ending date of your temporary address) (If your change of address is **permanent,** please enter your effective date in the beginning date only)*

BEGINNING DATE: Month Day Year

ENDING DATE: Month Day Year

SECTION III: HOMELESS INFORMATION

IMPORTANT: The following questions (Items 15A through 15F) should ***only*** be completed if you are currently homeless or at risk of becoming homeless. If this item does not apply to you, skip to Section IV.

15A. ARE YOU CURRENTLY HOMELESS?	15B. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:
☐ YES *(If "Yes," complete Item 15B regarding your living situation)* ☐ NO	☐ LIVING IN A HOMELESS SHELTER ☐ NOT CURRENTLY IN A SHELTERED ENVIRONMENT (e.g., living in a car or tent) ☐ STAYING WITH ANOTHER PERSON ☐ FLEEING CURRENT RESIDENCE ☐ OTHER (Specify):
15C. ARE YOU CURRENTLY AT RISK OF BECOMING HOMELESS?	15D. CHECK THE BOX THAT APPLIES TO YOUR LIVING SITUATION:
☐ YES *(If "Yes," complete Item 15D regarding your living situation)* ☐ NO	☐ HOUSING WILL BE LOST IN 30 DAYS ☐ LEAVING PUBLICLY FUNDED SYSTEM OF CARE (e.g., homeles shelter) ☐ OTHER (Specify):
15E. POINT OF CONTACT *(Name of person that VA can contact in order to get in touch with you)*	15F. POINT OF CONTACT TELEPHONE NUMBER *(Include Area Code)* **( )**

SECTION IV: CLAIM INFORMATION

16. LIST THE CURRENT DISABILITY(IES) OR SYMPTOMS THAT YOU CLAIM ARE RELATED TO YOUR MILITARY SERVICE AND/OR SERVICE-CONNECTED DISABILITY
(If applicable, identify whether a disability is due to a service-connected disability; confinement as a prisoner of war; exposure to Agent Orange, asbestos, mustard gas, ionizing radiation, or Gulf War environmental hazards; or a disability for which compensation is payable under 38 U.S.C. 1151)
NOTE: List your claimed conditions below. **See the following three examples for guidance on how to complete Section IV.**

EXAMPLES OF DISABILITY(IES)	EXAMPLES OF EXPOSURE TYPE	EXAMPLES OF HOW THE DISABILITY(IES) RELATE TO SERVICE	EXAMPLES OF DATES
Example 1. HEARING LOSS	NOISE	HEAVY EQUIPMENT OPERATOR IN SERVICE	JULY 1968
Example 2. DIABETES	AGENT ORANGE	SERVICE IN VIETNAM WAR	DECEMBER 1972
Example 3. LEFT KNEE, SECONDARY TO RIGHT KNEE		INJURED LEFT KNEE WHEN BRACE ON RIGHT KNEE FAILED	6/11/2008

	CURRENT DISABILITY(IES)	IF DUE TO EXPOSURE, EVENT, OR INJURY, PLEASE SPECIFY (e.g., Agent Orange, radiation)	EXPLAIN HOW THE DISABILITY(IES) RELATES TO THE IN-SERVICE EVENT/EXPOSURE/INJURY	APPROXIMATE DATE DISABILITY(IES) BEGAN OR WORSENED
1.	**Unspecified Anxiety Disorder**			**In Service**
2.	**Back Condition**			**In Service**
3.	**Left Shoulder**			**In Service**
4.	**Right Shoulder**			**In Service**
5.	**Migraine Headache**			**In Service**
6.	**Erectile Dysfunction**			**In Service**
7.	**Deviated Septum**			**In Service**
8.	**Asthma**			**In Service**
9				
10.				
11.				
12.				
13.				
14.				
15.				

VETERANS SOCIAL SECURITY NO **011-25-2006**

17. LIST VA MEDICAL CENTER(S) (VAMC) AND DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITIES (MTF) WHERE YOU RECEIVED TREATMENT AFTER DISCHARGE FOR YOUR CLAIMED DISABILITY(IES) LISTED IN ITEM 16 AND PROVIDE APPROXIMATE BEGINNING DATE (Month and Year) OF TREATMENT:
NOTE: If treatment began from 2005 to present, you do not need to provide dates in Item 17B.

A. ENTER THE DISABILITY TREATED AND NAME/LOCATION OF THE TREATMENT FACILITY	B. DATE OF TREATMENT (MM/YYYY)	C. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
		☐ Don't have date
		☐ Don't have date
		☐ Don't have date
		☐ Don't have date

NOTE: IF YOU WISH TO CLAIM ANY OF THE FOLLOWING, COMPLETE AND ATTACH THE REQUIRED FORM(S) AS STATED BELOW (VA forms are available at www.va.gov/vaforms).

For:	***Required Form(s):***
Supplemental Claims	VA Form 20-0995, *Decision Review Request: Supplemental Claim*
Dependents	VA Form 21-686c and, if claiming a child aged 18-23 years and in school, VA Form 21-674
Individual Unemployability	VA Form 21-8940 and 21-4192
Post-Traumatic Stress Disorder	VA Form 21-0781 and 21-0781a
Specially Adapted Housing or Special Home Adaptation	VA Form 26-4555
Auto Allowance	VA Form 21-4502
Veteran/Spouse Aid and Attendance benefits	VA Form 21-2680 or, if based on nursing home attendance, VA Form 21-0779

SECTION V: SERVICE INFORMATION

18A. DID YOU SERVE UNDER ANOTHER NAME?
☐ YES *(If "Yes," complete Item 18B)* ☑ NO *(If "No," skip to Item 19A)*

18B. PLEASE LIST THE OTHER NAME(S) YOU SERVED UNDER

19A. BRANCH OF SERVICE *(Check all that apply)*
☑ ARMY ☐ NAVY ☐ MARINE CORPS
☐ AIR FORCE ☐ COAST GUARD

19B. COMPONENT *(Check all that apply)*
☑ ACTIVE ☐ RESERVES ☐ NATIONAL GUARD

20A. MOST RECENT ACTIVE SERVICE ENTRY DATE *(MM,DD,YYYY)*
Month Day Year
ENTRY DATE: **06-01-1995**
EXIT DATE: **06-01-2018**

20B. PLACE OF LAST OR ANTICIPATED SEPARATION
New York

20C. DID YOU SERVE IN A COMBAT ZONE SINCE 9-11-2001?
☑ YES ☐ NO

20D. ADDITIONAL PERIODS OF SERVICE *(Indicate enlistment and discharge dates, if applicable)*

Enlistment Date(s)	Discharge Date(s)

21A. ARE YOU CURRENTLY SERVING OR HAVE YOU EVER SERVED IN THE RESERVES OR NATIONAL GUARD?
☐ YES *(If "Yes," complete Items 21B thru 21F)*
☑ NO *(If "No," skip to Item 22A)*

21B. COMPONENT
☐ NATIONAL GUARD
☐ RESERVES

21C. OBLIGATION TERM OF SERVICE
Month Day Year
From:
Month Day Year
To:

21D. CURRENT OR LAST ASSIGNED NAME AND ADDRESS OF UNIT:

21E. CURRENT OR ASSIGNED PHONE NUMBER OF UNIT *(Include Area Code)*
( )

21F. ARE YOU CURRENTLY RECEIVING INACTIVE DUTY TRAINING PAY?
☐ YES ☐ NO

22A. ARE YOU CURRENTLY ACTIVATED ON FEDERAL ORDERS WITHIN THE NATIONAL GUARD OR RESERVES?
☐ YES *(If "Yes," complete Items 22B & 22C)*
☑ NO

22B. DATE OF ACTIVATION: *(MM,DD,YYYY)*
Month Day Year

22C. ANTICIPATED SEPARATION DATE: *(MM,DD,YYYY)*
Month Day Year

23A. HAVE YOU EVER BEEN A PRISONER OF WAR?
☐ YES *(If "Yes," complete Item 23B)*
☑ NO

23B. DATES OF CONFINEMENT (MM,DD,YYYY)

From:	To:
Month Day Year	Month Day Year
Month Day Year	Month Day Year

SECTION VI: SERVICE PAY (Retired Pay, Separation Pay, and Disability Severance Pay)

24A. ARE YOU RECEIVING MILITARY RETIRED PAY?

☐ YES *(If "Yes," complete Items 24C and 24D)*

☑ NO

24B. WILL YOU RECEIVE MILITARY RETIRED PAY IN THE FUTURE?

☐ YES *(If "Yes," explain below (e.g. future Reserve/National Guard retirement, pending MEB/PEB and also complete Items 24C and 24D)*

☐ NO

24C. BRANCH OF SERVICE	24D. MONTHLY AMOUNT	25. RETIRED STATUS
	$	☐ RETIRED ☐ PERMANENT DISABILITY RETIRED LIST ☐ TEMPORARY DISABILITY RETIRED LIST

IMPORTANT INFORMATION ON MILITARY RETIRED PAY (Includes all Uniformed Services Retired Pay):
Submission of this application constitutes a waiver of military retired pay in an amount equal to VA compensation awarded, if you are entitled to both benefits. Your retired pay may be reduced by the amount of VA compensation awarded. Receipt of the full amount of military retired pay and VA compensation at the same time ***may*** result in an overpayment, which ***may*** be subject to collection. If you qualify for concurrent receipt of VA compensation and military retired pay, the waiver of retired pay will not apply. If you do not want to waive any retired pay to receive VA compensation, you should check the box in **Item 26. Note that if you check the box in Item 26, you will not receive VA compensation, if granted. If you are currently in receipt of VA compensation and you check the box in Item 26, your VA compensation will be terminated, if you are also eligible for military retired pay.**

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE, VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

☐ **26. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of retired pay.**

IMPORTANT INFORMATION ON SEPARATION/SEVERANCE PAY:
VA compensation, if granted, may be withheld to recoup any disability severance or separation pay such as involuntary separation pay, voluntary separation pay, or special separation benefit, you receive from your branch of service. In addition, if you receive a Voluntary Separation Incentive (VSI), your VSI payments may be reduced if you are awarded VA compensation. Receipt of VA compensation and VSI at the same time may result in an overpayment of VSI, which ***may*** be subject to collection.

27A. HAVE YOU EVER RECEIVED SEPARATION PAY, DISABILITY SEVERANCE PAY, OR ANY OTHER LUMP SUM PAYMENT FROM YOUR BRANCH OF SERVICE?

☐ YES *(If "Yes," complete Items 27B through 27D)*

☑ NO

27B. DATE PAYMENT RECEIVED *(MM,DD,YYYY)*	27C. BRANCH OF SERVICE	27D. AMOUNT RECEIVED *(Provide pre-tax amount)*
Month Day Year		$

IMPORTANT INFORMATION ON INACTIVE DUTY TRAINING PAY:
You may elect to keep the active or inactive duty training pay you received from the military service department. However, to be legally entitled to keep your training pay, you must waive VA benefits for the number of days equal to the number of days for which you received training pay. In most instances, it will be to your advantage to waive your VA benefits and keep your training pay.

If you waive VA benefits to receive training pay by checking the box in **Item 28**, VA will retroactively adjust your VA award to withhold benefits equal to the total number of training days waived and at the monthly rate in effect for the fiscal year period for which you received training pay. This action may result in an overpayment of compensation, which ***may*** be subject to collection.

IMPORTANT: VA COMPENSATION PAY IS NON-TAXABLE. THEREFORE VA COMPENSATION PAY MAY BE THE GREATER BENEFIT.

☐ **28. Do NOT pay me VA compensation. I do NOT want to receive VA compensation in lieu of training pay.**

SECTION VII: DIRECT DEPOSIT INFORMATION

The Department of the Treasury requires all Federal benefit payments be made by electronic funds transfer (EFT), also called direct deposit. To enroll in direct deposit, provide the information requested below, ***and*** attach either a voided personal check ***or*** a deposit slip. If you ***do not*** have a bank account, please visit https://www.benefits.va.gov/benefits/banking.asp. This website provides information about the Veterans Benefits Banking Program (VBBP), and a link to banks and credit unions that may fit your needs. You may also call 1-800-827-1000. If you elect not to enroll, you must contact representatives handling waiver requests for the Department of the Treasury at 1-888-224-2950. They will encourage your participation in EFT and address any questions or concerns you may have.

☐ 29. I CERTIFY THAT I DO NOT HAVE AN ACCOUNT WITH A FINANCIAL INSTITUTION OR CERTIFIED PAYMENT AGENT *(If you check this box skip to Section VIII)*

30. ACCOUNT NUMBER *(Check only one box below and provide the account number)*

Account No.: ☐ Checking ☐ Savings

31. NAME OF FINANCIAL INSTITUTION *(Please provide the name of the bank where you want your direct deposit)*	32. ROUTING OR TRANSIT NUMBER *(The first nine numbers located at the bottom left of your check)*

SECTION VIII: CLAIM CERTIFICATION AND SIGNATURE

VETERAN/SERVICEMEMBER CERTIFICATION AND SIGNATURE

I certify and authorize the release of information. I certify that the statements in this document are true and complete to the best of my knowledge. I authorize any person or entity, including but not limited to any organization, service provider, employer, or government agency, to give the Department of Veterans Affairs any information about me. For the limited purpose of providing VA with this information as it may relate to my claim, I waive any privilege that may apply and would otherwise make the information confidential and not disclosable.

I certify I have received the notice attached to this application titled, ***Notice to Veteran/Service Member of Evidence Necessary to Substantiate a Claim for Veterans Disability Compensation and Related Compensation Benefits***.

I certify I have enclosed all the information or evidence that will support my claim, to include an identification of relevant records available at a Federal facility such as a VA medical center; **OR**, I have no information or evidence to give VA to support my claim; **OR**, I have checked the box in Item 1, on page 8, indicating I want my claim processed under the standard claim process because I plan to submit additional evidence in support of my claim.

33A. VETERAN/SERVICE MEMBER SIGNATURE **(REQUIRED)** *(Sign in ink)*	33B. DATE SIGNED *(MM,DD,YYYY)*
Clint Barton	**06-03-2022**

SECTION IX: WITNESSES TO SIGNATURE

34A. SIGNATURE OF WITNESS *(Sign in ink)* (**Note**: *Only sign if veteran signed in Item 33A using an "X")*	34B. PRINTED NAME AND ADDRESS OF WITNESS
35A. SIGNATURE OF WITNESS *(Sign in ink)* (**Note**: *Only sign if veteran signed in Item 33A using an "X")*	35B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION X: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE

(NOTE: REQUIRED ONLY IF ITEM 33A IS BLANK)

I certify that by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

36A. ALTERNATE SIGNER SIGNATURE **(REQUIRED)** *(Sign in ink)*	36B. DATE SIGNED *(MM,DD,YYYY)*

SECTION XI: POWER OF ATTORNEY (POA) SIGNATURE

(NOTE: POA'S CANNOT SIGN FOR AN ORIGINAL CLAIM ONLY)

I certify that the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge. **NOTE**: A POA's signature *will not* be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative,* or VA Form 21-22a, *Appointment of Individual As Claimant's Representative,* indicating the appropriate POA is of record with VA.

37A. POA/AUTHORIZED REPRESENTATIVE SIGNATURE *(Sign in ink)*	37B. DATE SIGNED *(MM,DD,YYYY)*

PRIVACY ACT NOTICE: The form will be used to determine allowance to compensation benefits (38 U.S.C. 5101). The responses you submit are considered confidential (38 U.S.C. 5701). VA may disclose the information that you provide, including Social Security numbers, outside VA if the disclosure is authorized under the Privacy Act, including the routine uses identified in the VA system of records, 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records - VA, published in the Federal Register. The requested information is considered relevant and necessary to determine maximum benefits under the law. Information submitted is subject to verification through computer matching programs with other agencies. VA may make a "routine use" disclosure for: 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. Your obligation to respond is required in order to obtain or retain benefits. Information that you furnish may be utilized in computer matching programs with other Federal or State agencies for the purpose of determining your eligibility to receive VA benefits, as well as to collect any amount owed to the United States by virtue of your participation in any benefit program administered by the Department of Veterans Affairs. Social Security information: You are required to provide the Social Security number requested under 38 U.S.C. 5101(c)(1). VA may disclose Social Security numbers as authorized under the Privacy Act, and, specifically may disclose them for purposes stated above.

RESPONDENT BURDEN: We need this information to determine your eligibility for compensation. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 25 minutes to review the instructions, find the information, and complete this 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.

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it tobe false, or for the fraudulent acceptance of any payment to which you are not entitled.

THE CENTERS FOR ADVANCED ENT CARE

Alidad Arabshahi, M.D. Ramin Ipakchi, M.D. Alex Cheng, M.D. Nilofar Ariasaif, PA-C

14000 Crown Ct, #201 New York, NY 10004 6371 Little River Turnpike, 1" New York, NY 10012

385 Garrisonvile Rd, Stes. 208 & 209 New York NY 10003
212.499.8787 (phone) 212.499.8222 (fax)

March 8, 2022

Veteran: Barton, Clint
Veteran's SSN#xxx-xx-2006

To Whom It May Concern:

I am Dr. Alidad Arabshahi, board-certified Otolaryngologist. Below you will find my full credentials.

I have been treating Clint Barton (DOB 1/11/1977) for 3 years now due to his various respiratory conditions. While treating Mr. Barton, I have reviewed his medical records past and present to include his service treatment records and would like to provide you with the etiology of Mr. Barton's Deviated Septum.

While serving at Ft. Riley, KS Mr. Barton was conducting a field training exercise that consisted of nighttime mounted tank maneuvers. Due to poor visibility and high grass an order was given to re-position that tank which resulted in the tank dropping into a steep ditch. This flung Mr. Barton face-first into the .50 Cal mount where he sustained a bloody nose. Since no medics were on-site during the training exercise and there was no loss of consciousness, Mr. Barton continued the exercise.

Shortly after this, Mr. Barton started to experience breathing difficulties.

It is in my professional opinion that Mr. Barton's Deviated Septum is at least as likely as not caused or created by the above-mentioned incident. This opinion is based on over 23 years of specializing in ENT medicine and seeing numerous patients with deviated septum.

Signed,

Alidad Arabshahi, M.D.
Otolaryngologist
VA License: 0101234863
NPI: 1235200155

OMB Approved No. 2900-0881
Respondent Burden: 10 Minutes
Expiration Date: 06/30/2024

Department of Veterans Affairs

LAY/WITNESS STATEMENT

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 3. Use this form to submit a statement as a veteran/claimant or someone writing on your behalf to support a claim. If you or someone else writing on your behalf are providing additional statement(s) to support your claim(s) please submit this form with your application. For more information, contact us at https://iris.custhelp.va.gov, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at www.va.gov/vaforms. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable circle to help expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)

Clint D Barton

2. SOCIAL SECURITY NUMBER

011-25-2006

3. VA FILE NUMBER (If applicable)

4. DATE OF BIRTH

Month 01 – Day 11 – Year 1977

5. VA INSURANCE FILE NUMBER (If applicable)

6. CURRENT MAILING ADDRESS (If applicable) (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street: 890 Fifth Avenue

Apt./Unit Number:

City: New York

State/Province: NY

Country: US

ZIP Code/Postal Code: 10001 –

7. TELEPHONE NUMBER (Include Area Code)

336-867-5309

Enter International Phone Number (If applicable)

8. E-MAIL ADDRESS ◯ I agree to receive electronic correspondence from VA in regards to my claim.

Hawkeye222@gmail.com

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
(Complete this section ONLY IF the claimant is NOT the veteran)

9. CLAIMANT'S NAME (First, Middle Initial, Last)

10. SOCIAL SECURITY NUMBER

– –

11. VA FILE NUMBER (If applicable)

12. DATE OF BIRTH

Month – Day – Year

13. VA INSURANCE FILE NUMBER (If applicable)

14. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

15. TELEPHONE NUMBER (Include Area Code)

– –

Enter International Phone Number (If applicable)

16. E-MAIL ADDRESS ◯ I agree to receive electronic correspondence from VA in regards to my claim.

SOCIAL SECURITY NUMBER 0 1 1 – 2 5 – 2 0 0 6

SECTION III: STATEMENT

(Use this section to submit your statement, or a statement from someone else writing on your behalf)

NOTE: Please indicate the claimed issue that you are addressing. If you would like to submit an additional statement on your own behalf or if you have more than one witness writing on your behalf, use a separate form (VA Form 21-10210) for each statement.

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

On the night in question, I, SPC Steve Rodgers was the assigned driver of tank C23. My crew consisting of SSG Clint Barton , SGT Romanoff and PFC Banner and I were maneuvering in total darkness somewhere in the training area of Ft. Riley, KS. The drivers night vision device was installed and functioning properly. In addition, SSG Barton and PFC Banner were assisting my navigation efforts by using our assigned AN/PVS-7B night vision devices, also the vehicle headlights were on and operating with infrared lens covers installed. I believe we were attempting to rejoin the rest of our platoon that was located only a few kilometers away. As we were creeping along, we were tracking along a tree line that was on our left. We then saw a break in the tree line that appeared to offer passage in the general direction that we wished to travel. Upon command from SSG Barton, I halted the tank so that we could assess the situation. The break in the trees provided ample clearance for the tank to pass through. SSG Barton and PFC Banner both stated that the path looked clear. All that could be seen was chest-high prairie grass that was of a uniform height. SSG Barton then told me to proceed slowly to the left and through the gap in the trees. Looking into my night vision device, I concurred that the path looked clear, but all that I could see was grass. Upon instruction, I continued to proceed slowly into the gap, noticed more trees approximately 20-30 yards dead ahead. At this time, SSG Barton and PFC Banner also noticed the trees and I was then instructed to begin a slow right turn to continue to follow the trees. Then, without warning, the tank abruptly nosed down at about a 65A° angle and began to slide uncontrollably. Instantly realizing what had happened, I applied the service brake with both feet but to no avail. After a few seconds, the tank came to a halt, still nosed down at a steep angle with a 1A0 cant to the right. The tank sustained no damage due to the mine plow digging into the creek bed and absorbing the impact. SGT Romanoff, PFC Banner and myself sustained no serious injuries aside from minor bumps and scrapes. SSG Barton did not fare as well. When the tank came to a halt, his face impacted the .50 caliber machine gun resulting in a broken nose I believe. We exited the tank, looked each other over quickly and then made an immediate inventory of weapons and sensitive items, all were present. We had no medics on site so a correct diagnosis could not be made. To me it looked like SSG Barton just had a bloody nose.

SOCIAL SECURITY NUMBER 011-25-2006

SECTION III: STATEMENT (Continued)
(Use this section to submit your statement, or a statement from someone else writing on your behalf)

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

SECTION IV: WITNESS CONTACT INFORMATION
(Complete Section IV and V if the statement in Section III is from someone else writing on your behalf)

18. WITNESS NAME (First, Middle Initial, Last)

Steve L Rodgers

19. RELATIONSHIP TO VETERAN/CLAIMANT (Check all that apply)

- (●) SERVED WITH VETERAN/CLAIMANT
- ( ) FAMILY/FRIEND OF VETERAN/CLAIMANT
- ( ) COWORKER/SUPERVISOR OF VETERAN/CLAIMANT
- ( ) OTHER (Specify)

20. TELEPHONE NUMBER (Include Area Code)

336-926-6430

Enter International Phone Number (If applicable)

21. E-MAIL ADDRESS

CptAmerica@gmail.com

SECTION V: CERTIFICATION OF STATEMENT AND SIGNATURE

I CERTIFY THAT I have completed this statement and that its information is true and correct to the best of my knowledge and belief.

22A. VETERAN/CLAIMANT/WITNESS SIGNATURE ***(REQUIRED)***

Steve Rodgers

22B. DATE SIGNED

Month 05 – Day 01 – Year 2022

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact knowing it to be false, or for fraudulent receipt of any document to which you are not entitled.

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, 58VA21/22/28, Compensation, Pension, Education and Veteran Readiness and Employment Records -VA, published in the Federal Register. Your obligation to respond is voluntary.

RESPONDENT BURDEN: This form is used to submit a statement that supports a claim already pending or already established with VA. Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 10 minutes to review the instructions, find the information, and complete this 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.

OMB Approved No. 2900-0881
Respondent Burden: 10 Minutes
Expiration Date: 06/30/2024

Department of Veterans Affairs

LAY/WITNESS STATEMENT

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

INSTRUCTIONS: Before completing this form, read the Privacy Act and Respondent Burden on page 3. Use this form to submit a statement as a veteran/claimant or someone writing on your behalf to support a claim. If you or someone else writing on your behalf are providing additional statement(s) to support your claim(s) please submit this form with your application. For more information, contact us at https://iris.custhelp.va.gov, or call us toll-free at 1-800-827-1000. If you use a Telecommunications Device for the Deaf (TDD), the Federal relay number is 711. VA forms are available at www.va.gov/vaforms. After completing the form, mail to: **Department of Veterans Affairs, Evidence Intake Center, P.O. Box 4444, Janesville, WI 53547-4444.**

SECTION I: VETERAN'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly, insert one letter per box, and completely fill in each applicable circle to help expedite processing of the form.

1. VETERAN'S NAME (First, Middle Initial, Last)

Clint D Barton

2. SOCIAL SECURITY NUMBER

011-25-2006

3. VA FILE NUMBER (If applicable)

4. DATE OF BIRTH

Month 01 – Day 11 – Year 1977

5. VA INSURANCE FILE NUMBER (If applicable)

6. CURRENT MAILING ADDRESS (If applicable) (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street: 890 Fifth Avenue

Apt./Unit Number:

City: New York

State/Province: NY

Country: US

ZIP Code/Postal Code: 10001 –

7. TELEPHONE NUMBER (Include Area Code)

336-867-5309

Enter International Phone Number (If applicable)

8. E-MAIL ADDRESS ◯ I agree to receive electronic correspondence from VA in regards to my claim.

Hawkeye222@gmail.com

SECTION II: CLAIMANT'S IDENTIFICATION INFORMATION
(Complete this section ONLY IF the claimant is NOT the veteran)

9. CLAIMANT'S NAME (First, Middle Initial, Last)

10. SOCIAL SECURITY NUMBER

– –

11. VA FILE NUMBER (If applicable)

12. DATE OF BIRTH

Month – Day – Year

13. VA INSURANCE FILE NUMBER (If applicable)

14. CURRENT MAILING ADDRESS (Number and street or rural route, P.O. Box, City, State, ZIP Code and Country)

No. & Street

Apt./Unit Number

City

State/Province

Country

ZIP Code/Postal Code –

15. TELEPHONE NUMBER (Include Area Code)

– –

Enter International Phone Number (If applicable)

16. E-MAIL ADDRESS ◯ I agree to receive electronic correspondence from VA in regards to my claim.

SOCIAL SECURITY NUMBER 0 1 1 – 2 5 – 2 0 0 6

SECTION III: STATEMENT

(Use this section to submit your statement, or a statement from someone else writing on your behalf)

NOTE: Please indicate the claimed issue that you are addressing. If you would like to submit an additional statement on your own behalf or if you have more than one witness writing on your behalf, use a separate form (VA Form 21-10210) for each statement.

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

During my time stationed at Ft. Riley, KS, I served with the claimant, then Staff Sergeant Barton. SSG Barton was my tank commander in C Co. 2/34 Armor. I was assigned as his gunner.

Our unit was conducting a field training exercise at Ft. Riley and part of that exercise consisted of nighttime mounted tank maneuvers. To simulate battlefield conditions these maneuvers were conducted with little to no light and made use of night vision or thermal devices, making it difficult to see certain terrain features. Our tank was traveling through some very tall weeds further obscuring terrain features. From my position in the gunner's seat it appeared that we were traveling across flat terrain, the tops of the weeds seemed to be at the same level all along our path. As were were driving along, the tank did a nose dive and slammed to a stop as we entered a very deep ditch. I was thrust into the sight panel in front of me and all other members of the crew were thrown into anything that was in front of them. SSG Barton was thrown forward and hit his face on the .50 machine gun and mount. His face was bloodied. Our loader was almost fully ejected from his hatch and many things in our storage racks were thrown out. I can say the force left us all very sore for quite some time. During this small unit exercise, we did not have on-site support from any medics and received no treatment. There were no injuries, at the time, that required medical evacuation and we were instructed to recover the vehicle, repair any damage and continue training

SOCIAL SECURITY NUMBER 011-25-2006

SECTION III: STATEMENT (Continued)
(Use this section to submit your statement, or a statement from someone else writing on your behalf)

17. STATEMENT (Note: Describe what you yourself know or have observed about the facts or circumstances relevant to this claim before VA)

SECTION IV: WITNESS CONTACT INFORMATION
(Complete Section IV and V if the statement in Section III is from someone else writing on your behalf)

18. WITNESS NAME (First, Middle Initial, Last)

Tony D Stark

19. RELATIONSHIP TO VETERAN/CLAIMANT (Check all that apply)

- (●) SERVED WITH VETERAN/CLAIMANT
- ( ) FAMILY/FRIEND OF VETERAN/CLAIMANT
- ( ) COWORKER/SUPERVISOR OF VETERAN/CLAIMANT
- ( ) OTHER (Specify)

20. TELEPHONE NUMBER (Include Area Code)

336-575-6463

Enter International Phone Number (If applicable)

21. E-MAIL ADDRESS

iamironman@gmail.com

SECTION V: CERTIFICATION OF STATEMENT AND SIGNATURE

I CERTIFY THAT I have completed this statement and that its information is true and correct to the best of my knowledge and belief.

22A. VETERAN/CLAIMANT/WITNESS SIGNATURE ***(REQUIRED)***

Tony Stark

22B. DATE SIGNED

Month Day Year

05-11-2022

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