OMB Approved No. 2900-0776
Respondent Burden: 30 minutes

Department of Veterans Affairs

ANKLE CONDITIONS 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

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.

SECTION I - DIAGNOSIS

1A. DOES THE VETERAN HAVE AN ANKLE CONDITION?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO ANKLE CONDITIONS:

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -

1C. IF ADDITIONAL DIAGNOSIS PERTAINING TO ANKLE CONDITIONS, LIST USING ABOVE FORMAT

SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S ANKLE CONDITION *(brief summary)*

2B. DOES THE VETERAN REPORT THAT FLARE-UPS IMPACT THE FUNCTION OF THE AFFECTED JOINT(S)?

☐ YES ☐ NO *(If "Yes," document the veteran's description of the impact of flare-ups in his or her own words)*

SECTION III - INITIAL RANGE OF MOTION (ROM) MEASUREMENTS

3. MEASURE ROM WITH A GONIOMETER, ROUNDING EACH MEASUREMENT TO THE NEAREST 5 DEGREES. REPORT INITIAL MEASUREMENTS BELOW

A. RIGHT ANKLE ROM

Check box at which plantar flexion ends *(normal endpoint is 45 degrees)*:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 or greater

Check box at which dorsiflexion (extension) ends (normal endpoint is 20 degrees):

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 or greater

B. LEFT ANKLE ROM

Check box at which plantar flexion ends *(normal endpoint is 45 degrees)*:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 or greater

Check box at which dorsiflexion (extension) ends (normal endpoint is 20 degrees):

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 or greater

C. If ROM does not conform to the normal range of motion identified above but is normal for this veteran (for reasons other than an ankle condition, such as age, body habitus, neurologic disease), explain:

SECTION IV- ROM MEASUREMENTS AFTER REPETITIVE USE TESTING

NOTE - FOR VA PURPOSES, REPETITIVE - USE TESTING MUST ALSO BE PERFORMED. THE VA HAS DETERMINED THAT 3 REPETITIONS, AT MINIMUM, CAN SERVE AS A REPRESENTATIVE TEST FOR THE EFFECT OF REPETITIVE USE. FOLLOWING INITIAL ROM ASSESSMENT, THE CLINICIAN MUST PERFORM REPETITIVE - USE TESTING AND REPORT POST - TEST MEASUREMENTS.

A. Is the veteran able to perform repetitive-use testing with 3 repetitions?

☐ YES ☐ NO *(If unable, provide reason:)* ____________________

NOTE: If veteran is unable to perform repetitive-use testing, skip to Section 5.

NOTE: If veteran is able to perform repetitive-use testing, measure and report ROM after a minimum of 3 repetitions in Items 4B and 4C below.

B. RIGHT ANKLE POST-TEST ROM

Check box at which post-test plantar flexion ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 or greater

Check box at which post-test dorsiflexion (extension) ends

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 or greater

C. LEFT ANKLE POST-TEST ROM

Check box at which post-test plantar flexion ends:

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 ☐ 25 ☐ 30 ☐ 35 ☐ 40 ☐ 45 or greater

Check box at which post-test dorsiflexion (extension) ends

☐ 0 ☐ 5 ☐ 10 ☐ 15 ☐ 20 or greater

SECTION V- FUNCTIONAL LOSS AND ADDITIONAL LIMITATION IN ROM

5A. DOES THE VETERAN HAVE ANY FUNCTIONAL LOSS AND/OR FUNCTIONAL IMPAIRMENT OF THE ANKLE?

☐ YES ☐ NO

5B. DOES THE VETERAN HAVE ADDITIONAL LIMITATION IN ROM OF THE ANKLE FOLLOWING REPETITIVE-USE TESTING?

☐ YES ☐ NO

5C. IF THE VETERAN HAS FUNCTIONAL LOSS, FUNCTIONAL IMPAIRMENT AND/OR ADDITIONAL LIMITATION OF ROM OF THE ANKLE AFTER REPETITIVE USE, INDICATE THE CONTRIBUTING FACTORS OF DISABILITY BELOW *(Check all that apply and indicate side affected)*

☐ No functional loss for right lower extremity

☐ No functional loss for left lower extremity

☐ Less movement than normal ☐ Right ☐ Left ☐ Both

☐ More movement than normal ☐ Right ☐ Left ☐ Both

☐ Weakened movement ☐ Right ☐ Left ☐ Both

☐ Excess fatigability ☐ Right ☐ Left ☐ Both

☐ Incoordination, impaired ability to execute skilled movements ☐ Right ☐ Left ☐ Both

☐ Pain on movement ☐ Right ☐ Left ☐ Both

☐ Swelling ☐ Right ☐ Left ☐ Both

☐ Deformity ☐ Right ☐ Left ☐ Both

☐ Atrophy of disuse ☐ Right ☐ Left ☐ Both

☐ Instability of station ☐ Right ☐ Left ☐ Both

☐ Disturbance of locomotion ☐ Right ☐ Left ☐ Both

☐ Interference with sitting, standing and weight-bearing ☐ Right ☐ Left ☐ Both

SECTION VI - PAINFUL MOTION, TENDERNESS AND STRENGTH TESTING

6A. IS THERE OBJECTIVE EVIDENCE OF PAINFUL MOTION FOR EITHER ANKLE (evidenced by visible behavior, such as facial expression, wincing, etc.)?

☐ YES ☐ NO *(If "Yes," indicate side affected):* ☐ Right ☐ Left ☐ Both

6B. DOES THE VETERAN HAVE LOCALIZED TENDERNESS OR PAIN TO PALPATION FOR JOINTS/SOFT TISSUE OF EITHER ANKLE?

☐ YES ☐ NO *(If "Yes," indicate side affected):* ☐ Right ☐ Left ☐ Both

6C. STRENGTH TESTING - RATE STRENGTH ACCORDING TO THE FOLLOWING SCALE:

0/5 No muscle movement

1/5 Visible muscle movement, but no joint movement

2/5 No movement against gravity

3/5 No movement against resistance

4/5 Less than normal strength

5/5 Normal strength

Ankle plantar flexion:

Right ☐ 5/5 ☐ 4/5 ☐ 3/5 ☐ 2/5 ☐ 1/5 ☐ 0/5

Left ☐ 5/5 ☐ 4/5 ☐ 3/5 ☐ 2/5 ☐ 1/5 ☐ 0/5

Ankle dorsiflexion:

Right ☐ 5/5 ☐ 4/5 ☐ 3/5 ☐ 2/5 ☐ 1/5 ☐ 0/5

Left ☐ 5/5 ☐ 4/5 ☐ 3/5 ☐ 2/5 ☐ 1/5 ☐ 0/5

SECTION VII - JOINT STABILITY

7A. ANTERIOR DRAWER TEST - IS THERE LAXITY COMPARED WITH OPPOSITE SIDE?

☐ YES ☐ NO ☐ UNABLE TO TEST

(If "Yes," which side demonstrates laxity?) ☐ Right ☐ Left ☐ Both

7B. TALAR TILT TEST *(inversion/eversion stress)* - IS THERE LAXITY COMPARED WITH OPPOSITE SIDE?

☐ YES ☐ NO ☐ UNABLE TO TEST

(If "Yes," which side demonstrates laxity?) ☐ Right ☐ Left ☐ Both

SECTION VIII - ADDITIONAL CONDITIONS

8. DOES THE VETERAN HAVE "SHIN SPLINTS", STRESS FRACTURES, ACHILLES TENDONITIS, ACHILLES TENDON RUPTURE, ANKYLOSIS, MALUNION OF CALCANEUS OR TALUS, OR HAS THE VETERAN HAD A TALECTOMY?

☐ YES ☐ NO

(If "Yes," complete the questions below):

A. Does the veteran now have or has he or she ever had "shin splints"?

☐ YES ☐ NO *(If "Yes," indicate side affected):* ☐ Right ☐ Left ☐ Both

Describe current symptoms:

B. Does the veteran now have or has he or she ever had stress fractures of the lower extremity(ies)?

☐ YES ☐ NO *(If "Yes," indicate side affected):* ☐ Right ☐ Left ☐ Both

Describe current symptoms:

C. Does the veteran now have or has he or she ever had Achilles tendonitis or Achilles tendon rupture?

☐ YES ☐ NO *(If "Yes," indicate side affected):* ☐ Right ☐ Left ☐ Both

Describe current symptoms:

D. Does the veteran now have ankylosis of the ankle, subtalar and/or tarsal joint?

☐ YES ☐ NO *(If "Yes," indicate severity of ankylosis and side affected (check all that apply)*

In plantar flexion, less than 30º ☐ Right ☐ Left ☐ Both
In plantar flexion, between 30º and 40º ☐ Right ☐ Left ☐ Both
In plantar flexion, at more than 40º ☐ Right ☐ Left ☐ Both
In dorsiflexion, between 0º and 10º ☐ Right ☐ Left ☐ Both
In dorsiflexion at more than 10º ☐ Right ☐ Left ☐ Both
With abduction, adduction, inversion or eversion deformity ☐ Right ☐ Left ☐ Both
In good weight-bearing position ☐ Right ☐ Left ☐ Both
In poor weight-bearing position ☐ Right ☐ Left ☐ Both

E. Does the veteran have malunion of calcaneus or talus?

☐ YES ☐ NO *(If "Yes," indicate severity and side affected)*

☐ Moderate ☐ Right ☐ Left ☐ Both
☐ Marked deformity ☐ Right ☐ Left ☐ Both

SECTION IX - JOINT REPLACEMENT AND/OR OTHER SURGICAL PROCEDURES

9A. HAS THE VETERAN HAD A TOTAL ANKLE JOINT REPLACEMENT?

☐ YES ☐ NO *(If "Yes," indicate side and severity of residuals)*

☐ Right ankle

Date of surgery: ____________

Residuals:

☐ None
☐ Intermediate degrees of residual weakness, pain and/or limitation of motion
☐ Chronic residuals consisting of severe painful motion and/or weakness
☐ Other, describe: ____________

☐ Left ankle

Date of surgery: ____________

Residuals:

☐ None
☐ Intermediate degrees of residual weakness, pain and/or limitation of motion
☐ Chronic residuals consisting of severe painful motion and/or weakness
☐ Other, describe: ____________

SECTION IX - JOINT REPLACEMENT AND/OR OTHER SURGICAL PROCEDURES *(Continued)*

9B. HAS THE VETERAN HAD ARTHROSCOPIC OR OTHER ANKLE SURGERY?

☐ YES ☐ NO

(If "Yes," indicate side affected) ☐ Right ☐ Left ☐ Both

Date and type of surgery:

9C. DOES THE VETERAN HAVE ANY RESIDUAL SIGNS AND/OR SYMPTOMS DUE TO ARTHROSCOPIC OR OTHER ANKLE SURGERY?

☐ YES ☐ NO

(If "Yes," indicate side affected) ☐ Right ☐ Left ☐ Both

(If "Yes," describe symptoms):

SECTION X - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

10. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS?

☐ YES ☐ NO

(If "Yes," describe):

SECTION XI - ASSISTIVE DEVICES AND REMAINING FUNCTION OF THE EXTREMITIES

11A. 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 device(s) used (check all that apply and indicate frequency):*

☐ WHEELCHAIR Frequency of use: ☐ Occasional ☐ Regular ☐ Constant

☐ BRACE(S) Frequency of use: ☐ Occasional ☐ Regular ☐ Constant

☐ CRUTCH(ES) Frequency of use: ☐ Occasional ☐ Regular ☐ Constant

☐ CANE(S) Frequency of use: ☐ Occasional ☐ Regular ☐ Constant

☐ WALKER Frequency of use: ☐ Occasional ☐ Regular ☐ Constant

☐ OTHER: ____________________

(If "Yes," identify and describe each condition(s) causing the need for assistive device(s)):

11B. DUE TO THE SERVICE-CONNECTED DISABLING CONDITION(S), 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 extremity(ies) (check all extremities for which this applies)

☐ Right upper ☐ Left upper ☐ Right lower ☐ Left lower

Describe diminished function of each indicated extremity:

SECTION XII - DIAGNOSTIC TESTING

NOTE - The diagnosis of arthritis must be confirmed by imaging studies. Once arthritis has been documented, no further imaging studies are indicated, even if arthritis has worsened.

12A. HAVE IMAGING STUDIES OF THE ANKLE BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

(If "Yes," is arthritis documented?)

☐ YES ☐ NO

(If "Yes," indicate ankle)

☐ Right ☐ Left ☐ Both

12B. 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 XIII - FUNCTIONAL IMPACT AND REMARKS

13. DOES THE VETERAN'S ANKLE CONDITION(S) IMPACT HIS OR HER ABILITY TO WORK?

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

14. REMARKS *(If any)*

SECTION XIV - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

15A. PHYSICIAN'S SIGNATURE	15B. PHYSICIAN'S PRINTED NAME	15C. DATE SIGNED

15D. PHYSICIAN'S PHONE NUMBER	15E. PHYSICIAN'S MEDICAL LICENSE NUMBER	15F. PHYSICIAN'S ADDRESS

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

IMPORTANT - Physician please fax the completed form to ______________________________

(VA Regional Office FAX No.)

NOTE - A list of VA Regional Office FAX Numbers can be found at www.vba.va.gov/disabilityexams or obtained by calling 1-800-827-1000.

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 required to obtain or retain benefits. 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 30 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.