OMB Control No. 2900-0781 Respondent Burden: 15 Minutes Expiration Date: 09/30/2019

							Ez	xpiration	Date:	09/30/	2015	)
Department of Veterans Affairs CHRONIC FATIGUE SYNDROME DISABILITY BENEFITS QUESTIONNAIRE												
IMPORTANT - THE DEPARTMENT OF VETERANS AT PROCESS OF COMPLETING AND/OR SUBMITTING T.	\ /											
BEFORE COMPLETING THIS FORM.	nis form. Pleas	SE KEAD IND	PRIVACI	ACI	AND KE	SPOR	NDEN	I BUKL	EN I	NFOR	VIA I	ION
NAME OF PATIENT/VETERAN (First, Middle Initial, Last)												
	7											
PATIENT/VETERAN'S SOCIAL SECURITY NUMBER												Щ
PATIENT/VETERANS 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. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.												
as part of their evaluation in processing the veteran's claim. VA reserves the right to confirm the authenticity of ALL DBQs completed by private health care providers.  SECTION I - DIAGNOSIS												
SECTION 1 - DIAGNOSIS  1A. DOES THE VETERAN NOW HAVE OR HAS HE OR SHE EVER BEEN DIAGNOSED WITH CHRONIC FATIGUE SYNDROME?												
YES NO (If "Yes," complete Item 1B)												
	ion of the claimed cond	lition(s) listed abo	ove. If there is	no diagr	osis, if the	e diagn	osis is	different f	rom a	previous	diag	nosis
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												he
evaluation if the clinician is making the initial diagnosis, or an appropriate date determined through record review orreported history.  1B. SELECT THE VETERAN'S CONDITION (check all that apply)												
	• *											
CHRONIC FATIGUE SYNDROME	ICD Code: _					Date c	of diag	nosis:				
☐ OTHER (specify)												
Other diagnosis #1							_	nosis:				
Other diagnosis #2  1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIL		IGHE SYNDRO		ING AF				nosis:				
10. II THERE ARE ABBITIONAL BIAGNOSES THAT I ERTAIN	VIO OFFICIALOTATI	IOOL OTTIDITO	IVIL, LIOT OO	/// / / L	OVEIO	i (ivi) ( i						
NOTE TO ALL AND A SECOND												
NOTE - For VA purposes, the diagnosis of chronic fatigue sy (A) New onset of debilitating fatigue severe enough to reduce		than 50 narras	ot of the usua	1 lovol	for at loa	at 6 m	ontho	. and				
(B) The exclusion, by history, physical examination, and labo												
(C) Six or more of the following:	,,			J F			, <b>r</b>	,				
1. Acute onset of the condition	7. Headaches (of a	type, severity	or pattern tha	at is dif	ferent fro	m hea	adache	es in the p	ore-mo	orbid st	ate)	
2. Low grade fever	8. Migratory joint	pains	•									
Non-exudative pharyngitis     Palpable or tender cervical or axillary lymph nodes	<ol> <li>Neuropsycholog</li> <li>Sleep disturbat</li> </ol>											
5. Generalized muscle aches or weakness	10. Sieep disturbai	nce										
6. Fatigue lasting 24 hours or longer after exercise												
S	ECTION II - MEDIO	CAL RECORI	REVIEW									
2. INDICATE MEDICAL RECORDS REVIEWED IN PREPARAT	ION OF THIS REPO	RT:										
C-FILE (VA ONLY)												
OTHER, DESCRIBE:												
OTTIER, DESCRIBE.	SECTION III - I	MEDICAL HIS	TORY									
3A. DESCRIBE THE HISTORY (including onset and course) C				OME (	brief sum	marv)	) •					
W. BESSTUBE THE THOTOTT (menually short and country)	· · · · · · · · · · · · · · · · · · ·		002 0111011	( LOINE (	or vey sum.		•					
3B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTR	OL OF CHRONIC FA	TIGUE SYNDR	OME?									
└ YES └ NO												
(If "Yes," are the veteran's symptoms controlled by continuous medication?)												
☐ YES ☐ NO												
(If "Yes," list only those medications required for the veteran's chronic fatigue syndrome):												
3C. HAVE OTHER CLINICAL CONDITIONS THAT MAY PROD	LICE SIMIL AR SYMP	TOMS BEEN E	XCLUDED B	Y HIST	ORY PH	YSICA	AI FX	AMINATIO	ON AN	ID/OR		
3C. HAVE OTHER CLINICAL CONDITIONS THAT MAY PRODUCE SIMILAR SYMPTOMS BEEN EXCLUDED BY HISTORY, PHYSICAL EXAMINATION AND/OR LABORATORY TESTS TO THE EXTENT POSSIBLE?												
YES NO (If "No," describe):												
3D. DID THE VETERAN HAVE AN ACUTE ONSET OF CHRON	IIC FATIGUE SYNDF	ROME?										
YES NO												
3E. HAS THE DEBILITATING FATIGUE REDUCED DAILY ACT	IVITY LEVEL TO LE	SS THAN 50%	OF PRE-ILLN	NESS L	EVEL?							
YES NO												
(If "Yes," specify length of time daily activity level has been re	educed to less than 5	0% of pre-illne	ss level):									

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER			- 📖					
	SECTIO	N IV - F	INDINGS,	SIGNS	AND SY	MPTO	MS	
4A. DOES THE VETERAN NOW HAVE OR HAS THE VE	TERAN	HAD AN	Y FINDINGS	s, SIGNS	S AND SYM	IPTOMS	S AT	TRIBUTABLE TO CHRONIC FATIGUE SYNDROME?
YES NO								
(If "Yes," check all that apply):								
Debilitating fatigue								
Low grade fever								
Nonexudative pharyngitis								
Palpable or tender cervical or axillary lymph nodes Generalized muscle aches or weakness								
Fatigue lasting 24 hours or longer after exercise								
Headaches (of a type, severity or pattern that is di	ifferent fr	rom head	daches in th	e pre-mo	orbid state)	)		
Migratory joint pain				•	ŕ			
Neuropsychologic symptoms								
☐ Sleep disturbance								
Other								
(Note: Describe all checked conditions in Item 4B)								
4B. PROVIDE A DESCRIPTION OF THE CONDITION(S)	):							
4C. DOES THE VETERAN NOW HAVE OR HAS THE VE	TERANI	ΗΔΠ ΔΝ'	Y COGNITI\	/F IMPΔ	IRMENT A	TTRIBLI	ΙΤΔΕ	RI E TO CHRONIC FATIGUE SYNDROME?
YES NO		11/10/111	1 00011111	/ L IIVII / \		TTTT	, , , , ,	LE TO OFFICIAL TATIONE STABLES
(If "Yes," check all that apply):								
Poor attention								
Inability to concentrate								
Forgetfulness								
Confusion								
Other cognitive impairments (Note: Describe all checked conditions in Item 4D)								
4D. PROVIDE A DESCRIPTION OF THE CONDITION(S)	):							
,								
4E. SPECIFY FREQUENCY OF SYMPTOMS:								
Symptoms wax and wane								
Symptoms are nearly constant  Other								
(Note: Describe frequency in Item 4F)								
4F. PROVIDE A DESCRIPTION OF THE FREQUENCY:								
41. PROVIDE A DESCRIPTION OF THE FREQUENCY.								
4G. DO THE VETERAN'S SYMPTOMS DUE TO CHRONI	C FATIG	UE SYNI	DROME RES	STRICT	ROUTINE [	DAILY A	CTI	/ITIES AS COMPARED TO THE PRE-ILLNESS LEVEL?
YES NO								
(If "Yes," specify % of restriction (check all that apply))								
Symptoms restrict routine daily activities by less tha				(more t	han 75% oʻ	f the pre	e-illi	ness level of activities are not restricted)
Symptoms restrict routine daily activities to 50% to 7		-						
Symptoms restrict routine daily activities to less than Symptoms are so severe as to restrict routine daily		-						
Symptoms are so severe as to occasionally preclud				ibe freat	uencv with	which t	this o	occurs):
Other (describe):		- ()	,	J 1				
NOTE: For VA purposes, chronic fatigue syndrome is	considere	ed incan	acitating on	lv while	it requires	hed res	st and	d treatment by a physician
4H. DO THE VETERAN'S SYMPTOMS DUE TO CHRON								
YES NO		- 0 - 0 110					J, 11	
(If "Yes," indicate total duration of periods of incapacity	ation ove	er the pa	st 12 month	s):				
Less than 1 week		-						
At least 1 but less than 2 weeks								
At least 2 but less than 4 weeks								
At least 4 but less than 6 weeks								
At least 6 weeks total duration per year								
U Other (describe):								

VA FORM 21-060Q-1, SEP 2016 Page 2

PATIENT/VETERAN'S SOCIAL SECURITY NUMBER											
SECTION V - OTHER PERTINENT PHY	SICAL FI	NDING	3, SCA	ARS, C	OMPL	ICAT	IONS, C	CONDITIONS, SIGNS	S AND/OR SYMPTOMS		
5A. DOES THE VETERAN HAVE ANY SCARS (surgice DIAGNOSIS SECTION?  YES NO	al or otherw	rise) REL	ATED <sup>-</sup>	TO ANY	CONE	MOITIC	NS OR TO	O THE TREATMENT OF	: ANY CONDITIONS LISTED IN THE		
IF "YES," ARE ANY OF THESE SCARS PAINFUL AND/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?  YES NO											
IF "YES," ALSO COMPLETE VA FORM 21-0960F-1, SCARS/DISFIGUREMENT DISABILITY BENEFITS QUESTIONNAIRE (DBQ).											
IF "NO," PROVIDE LOCATION AND MEASUREMENTS OF SCAR IN CENTIMETERS.											
LOCATION: mEASUREMENTS: Length cm X width cm.											
NOTE: An "unstable scar" is one where, for any reason, there is frequent loss of covering of the skin over the scar. If there are multiple scars, enter additional locations and measurements in the "Remarks" section. It is not necessary to also complete a Scars/Disfigurement DBQ.											
5B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS OF CHRONIC FATIGUE SYNDROME?  YES NO (If "Yes," describe (brief summary)):											
SECTION VI - DIAGNOSTIC TESTING											
NOTE: If the time has been suffered and suffered to								<u> </u>			
NOTE: If testing has been performed and reflects the veteran's current condition, repeat testing is not required.											
6. ARE THERE ANY 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											
7. DOES THE VETERAN'S CHRONIC FATIGUE SYND											
YES NO (If "Yes," describe the impact of the veteran's chronic fatigue syndrome, providing one or more examples):											
SECTION VIII - REMARKS											
8. REMARKS (If any):											
SECTION IX - PHYSICIAN'S CERTIFICATION AND SIGNATURE											
CERTIFICATION - To the best of my knowledge, the information contained herein is accurate, complete and current.											
PA. PHYSICIAN'S SIGNATURE  9B. PHYSICIAN'S PRINTED NAME  9C. DATE SIGNED								9C. DATE SIGNED			
9D. PHYSICIAN'S PHONE/FAX NUMBERS	9E. NATIO	NATIONAL PROVIDER IDENTIFIER (NPI) NUMBER 9F. 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.benefits.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 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 <a href="https://www.reginfo.gov/public/do/PRAMain">www.reginfo.gov/public/do/PRAMain</a>. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

VA FORM 21-0960Q-1, SEP 2016 Page 3