Department of Veterans Affairs

# CHRONIC FATIGUE SYNDROME (CFS) DISABILITY BENEFITS QUESTIONNAIRE

| NAME OF PATIENT/VETERAN | PATIENT/VETERAN'S SOCIAL SECURITY NUMBER |
|---|---|
| | |

**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.**

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

☐ Veteran/Claimant

☐ Other, please describe:

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?

## EVIDENCE REVIEW

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.

## SECTION I - DIAGNOSIS

1A. DOES THE VETERAN CURRENTLY HAVE CHRONIC FATIGUE SYNDROME (CFS)?

☐ YES ☐ NO ICD code: _____ Date of diagnosis: _____

☐ OTHER (specify)

Other diagnosis #1 _____ ICD code: _____ Date of diagnosis: _____

Other diagnosis #2 _____ ICD code: _____ Date of diagnosis: _____

1B. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO CHRONIC FATIGUE SYNDROME, LIST USING ABOVE FORMAT:

NOTE - For VA purposes, the diagnosis of Chronic Fatigue Syndrome requires:
(A) New onset of debilitating fatigue severe enough to reduce daily activity to less than 50 percent of the usual level for at least 6 months; and
(B) The exclusion, by history, physical examination, and laboratory tests, of all other clinical conditions that may produce similar symptoms; and
(C) Six or more of the following:

1. Acute onset of the condition
2. Low grade fever
3. Non-exudative pharyngitis
4. Palpable or tender cervical or axillary lymph nodes
5. Generalized muscle aches or weakness
6. Fatigue lasting 24 hours or longer after exercise
7. Headaches (of a type, severity or pattern that is different from headaches in the pre-morbid state)
8. Migratory joint pains
9. Neuropsychologic symptoms
10. Sleep disturbance

## SECTION II - MEDICAL HISTORY

2A. DESCRIBE THE HISTORY (including onset and course or whether the condition is now completely resolved and no longer requires treatment of any type) OF THE VETERAN'S CHRONIC FATIGUE SYNDROME (brief summary):

2B. IS CONTINUOUS MEDICATION REQUIRED FOR CONTROL OF CHRONIC FATIGUE SYNDROME?

☐ 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:

2C. 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:

## SECTION II - MEDICAL HISTORY (continued)

2D. DID THE VETERAN HAVE AN ACUTE ONSET OF CHRONIC FATIGUE SYNDROME?

☐ YES ☐ NO

2E. HAS THE DEBILITATING FATIGUE REDUCED DAILY ACTIVITY LEVEL TO LESS THAN 50% OF PRE-ILLNESS LEVEL?

☐ YES ☐ NO

If "Yes," specify length of time daily activity level has been reduced to less than 50% of pre-illness level:

☐ Less than 6 months ☐ 6 months or longer

## SECTION III - FINDINGS, SIGNS AND SYMPTOMS

3A. DOES THE VETERAN NOW HAVE OR HAS THE VETERAN HAD ANY FINDINGS, SIGNS AND SYMPTOMS ATTRIBUTABLE 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 different from headaches in the pre-morbid state)
☐ Migratory joint pain
☐ Neuropsychologic symptoms
☐ Sleep disturbance
☐ Other

FOR ALL CHECKED CONDITIONS, DESCRIBE:

3B. DOES THE VETERAN NOW HAVE OR HAS THE VETERAN HAD ANY COGNITIVE IMPAIRMENT ATTRIBUTABLE TO CHRONIC FATIGUE SYNDROME?

☐ YES ☐ NO

If "Yes," check all that apply:

☐ Inability to concentrate
☐ Forgetfulness
☐ Confusion
☐ Other cognitive impairments

FOR ALL CHECKED CONDITIONS, DESCRIBE:

3C. SPECIFY FREQUENCY OF SYMPTOMS:

☐ Symptoms are nearly constant (if checked complete question 3D)
☐ Symptoms wax and wane (if checked skip to question 3E)

## SECTION III - FINDINGS, SIGNS AND SYMPTOMS (continued)

3D. IF THE SYMPTOMS DUE TO CHRONIC FATIGUE SYNDROME ARE NEARLY CONSTANT, DO THEY RESTRICT ROUTINE DAILY ACTIVITIES AS COMPARED TO THE PRE-ILLNESS LEVEL?

☐ YES ☐ NO

If "Yes," specify % of restriction (check all that apply)

- ☐ Symptoms restrict routine daily activities almost completely and may occasionally preclude self-care
- ☐ Symptoms restrict routine daily activities to less than 50 percent of the pre-illness level
- ☐ Symptoms restrict daily activities from 50 to 75 percent of the pre-illness level
- ☐ Symptoms restrict routine daily activities by less than 25 percent of the pre-illness level
- ☐ Other (describe):

NOTE: For VA purposes, Chronic Fatigue Syndrome is considered incapacitating only while it requires bed rest and treatment by a physician.

3E. DO THE VETERAN'S SYMPTOMS DUE TO CHRONIC FATIGUE SYNDROME RESULT IN PERIODS OF INCAPACITATION?

☐ YES ☐ NO

If "Yes," indicate total duration of periods of incapacitation:

- ☐ At least 6 weeks per year
- ☐ At least 4 but less than 6 weeks per year
- ☐ At least 2 but less than 4 weeks per year
- ☐ At least 1 but less than 2 weeks per year
- ☐ Less than 1 week per year

## SECTION IV - OTHER PERTINENT PHYSICAL FINDINGS, SCARS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS

4A. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY OF THE CONDITIONS LISTED IN THE DIAGNOSIS SECTION?

☐ YES ☐ NO IF YES, DESCRIBE (brief summary):

4B. 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 appropriate dermatological DBQ

## SECTION V - DIAGNOSTIC TESTING

NOTE: If testing has been performed and reflects the Veteran's current condition, repeat testing is not required.

5A. 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 VI - FUNCTIONAL IMPACT

6A. DOES THE VETERAN'S CHRONIC FATIGUE SYNDROME IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO If "Yes," describe the impact of the Veteran's Chronic Fatigue Syndrome, providing one or more examples:

## SECTION VII - REMARKS

7A. REMARKS (If any)

## 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):

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

8D. Date Signed:

8E. Examiner's phone/fax numbers:

8F. National Provider Identifier (NPI) number:

8G. Medical license number and state:

8H. Examiner's address: