



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:

Text input box for describing other requestor.

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?

Text input box for describing examination method.

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.

Large text input box for identifying evidence reviewed.

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

**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:

- |  |  |
|--|--|
| <input type="checkbox"/> Debilitating fatigue                                | <input type="checkbox"/> Headaches (of a type, severity or pattern that is different from headaches in the pre-morbid state) |
| <input type="checkbox"/> Low grade fever                                     | <input type="checkbox"/> Migratory joint pain  |
| <input type="checkbox"/> Nonexudative pharyngitis                            | <input type="checkbox"/> Neuropsychologic symptoms   |
| <input type="checkbox"/> Palpable or tender cervical or axillary lymph nodes | <input type="checkbox"/> Sleep disturbance   |
| <input type="checkbox"/> Generalized muscle aches or weakness                | <input type="checkbox"/> Other   |
| <input type="checkbox"/> Fatigue lasting 24 hours or longer after exercise   |  |

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: