Department of Veterans Affairs

# HEADACHES (INCLUDING MIGRAINE HEADACHES) 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

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

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

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

| | | |
|---|---|---|
| ☐ Migraine including migraine variants | ICD Code: _____ | Date of Diagnosis: _____ |
| ☐ Tension | ICD Code: _____ | Date of Diagnosis: _____ |
| ☐ 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):*

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):*

## 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 *(Continued)*

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. MIGRANE / 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):*

## SECTION VIII - REMARKS

8. REMARKS *(If any)*

## SECTION IX - EXAMINER'S CERTIFICATION AND SIGNATURE

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

| 9A. Examiner's signature: | 9B. Examiner's printed name and title (e.g. MD, DO, DDS, DMD, Ph.D, Psy.D, NP, PA-C): |
|---|---|
| | |

| 9C. Examiner's Area of Practice/Specialty (e.g. Cardiology, Orthopedics, Psychology/Psychiatry, General Practice): | 9D. Date Signed: |
|---|---|
| | |

| 9E. Examiner's phone/fax numbers: | 9F. National Provider Identifier (NPI) number: | 9G. Medical license number and state: |
|---|---|---|
| | | |

9H. Examiner's address: