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

Department of Veterans Affairs

FLATFOOT (PES PLANUS) 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 NOW HAVE OR HAS HE/SHE EVER HAD FLATFOOT (PES PLANUS)?

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

1B. PROVIDE ONLY DIAGNOSES THAT PERTAIN TO FLATFOOT:

DIAGNOSIS # 1 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED ☐ RIGHT ☐ LEFT ☐ BOTH
DIAGNOSIS # 2 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED ☐ RIGHT ☐ LEFT ☐ BOTH
DIAGNOSIS # 3 -	ICD CODE -	DATE OF DIAGNOSIS -	SIDE AFFECTED ☐ RIGHT ☐ LEFT ☐ BOTH

1C. IF THERE ARE ADDITIONAL DIAGNOSES THAT PERTAIN TO FLATFOOT, LIST USING ABOVE FORMAT

NOTE - If the veteran has additional foot conditions other than flatfoot, (such as extreme tenderness on the plantar surfaces of the feet indicating plantar fasciitis), complete a VAF 21-0960M-6 Foot (other than flatfoot) Disability Benefits Questionnaire.

SECTION II - MEDICAL HISTORY

2. DESCRIBE THE HISTORY *(including onset and course)* OF THE VETERAN'S CURRENT FLATFOOT CONDITION *(i.e., when did flatfoot first become symptomatic?) (brief summary)*:

SECTION III - SIGNS AND SYMPTOMS

NOTE: INDICATE ALL SIGNS AND SYMPTOMS THAT APPLY TO THE VETERAN'S FLATFOOT CONDITION, REGARDLESS OF WHETHER SIMILAR SIGNS AND SYMPTOMS APPEAR MORE THAN ONCE IN DIFFERENT SECTIONS

3A. DOES THE VETERAN HAVE PAIN ON USE OF THE FEET?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

If "Yes," is the pain accentuated on use?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

3B. DOES THE VETERAN HAVE PAIN ON MANIPULATION OF THE FEET?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

If "Yes," is the pain accentuated on manipulation?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

SECTION III - SIGNS AND SYMPTOMS *(Continued)*

3C. IS THERE INDICATION OF SWELLING ON USE?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

3D. DOES THE VETERAN HAVE CHARACTERISTIC CALLUSES (OR ANY CALLUSES CAUSED BY THE FLATFOOT CONDITION)?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

3E. ARE THE VETERAN'S SYMPTOMS RELIEVED BY ARCH SUPPORTS (OR BUILT UP SHOES OR ORTHOTICS)?

☐ YES ☐ NO

If "No," indicate side that remains symptomatic despite arch supports or orthotics:

☐ Right ☐ Left ☐ Both

3F. DOES THE VETERAN HAVE EXTREME TENDERNESS OF PLANTAR SURFACES ON ONE OR BOTH FEET?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

Is the tenderness improved by orthopedic shoes or appliances?

☐ YES ☐ NO

SECTION IV - ALIGNMENT AND DEFORMITY

4A.. DOES THE VETERAN HAVE DECREASED LONGITUDINAL ARCH HEIGHT ON WEIGHT-BEARING?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

4B.. IS THERE OBJECTIVE EVIDENCE OF MARKED DEFORMITY OF THE FOOT *(pronation, abduction etc.)*?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

4C. IS THERE MARKED PRONATION OF THE FOOT?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

if "Yes," is the condition improved by orthopedic shoes or appliances?

☐ YES ☐ NO

4D. DOES THE WEIGHT-BEARING LINE FALL OVER OR MEDIAL TO THE GREAT TOE?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

4E. IS THERE A LOWER EXTREMITY DEFORMITY OTHER THAN PES PLANUS, CAUSING ALTERATION OF THE WEIGHT-BEARING LINE?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

Describe lower extremity deformity other than pes planus causing alteration of the weight bearing line: ______________________

4F. DOES THE VETERAN HAVE "INWARD" BOWING OF THE ACHILLES' TENDON *(i.e., hindfoot valgus, with lateral deviation of the heel)*?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

4G. DOES THE VETERAN HAVE MARKED INWARD DISPLACEMENT AND SEVERE SPASM OF THE ACHILLES' TENDON *(rigid hindfoot)* ON MANIPULATION?

☐ YES ☐ NO

If "Yes," indicate side affected: ☐ Right ☐ Left ☐ Both

Is the marked inward displacement and severe spasm of the Achilles tendon improved by orthopedic shoes or appliances?

☐ YES ☐ NO

If "Yes," indicate side improved by orthopedic shoes or appliances:

☐ Right ☐ Left ☐ Both

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

5A. DOES THE VETERAN HAVE ANY SCARS *(surgical or otherwise)* RELATED TO ANY CONDITIONS OR TO THE TREATMENT OF ANY CONDITIONS LISTED IN SECTION I, DIAGNOSIS?

☐ YES ☐ NO

IF YES, ARE ANY OF THE SCARS PAINFUL AND/OR UNSTABLE, OR IS THE TOTAL AREA OF ALL RELATED SCARS GREATER THAN 39 SQUARE CM *(6 square inches)*?

☐ YES ☐ NO IF YES, ALSO COMPLETE A VAF 21-0960F-1 Scars/Disfigurement Disability Benefits Questionnaire.

SECTION V - OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS *(Continued)*

5B. DOES THE VETERAN HAVE ANY OTHER PERTINENT PHYSICAL FINDINGS, COMPLICATIONS, CONDITIONS, SIGNS AND/OR SYMPTOMS RELATED TO ANY CONDITIONS LISTED IN SECTION 1, DIAGNOSIS?

☐ YES ☐ NO

IF YES, DESCRIBE *(brief summary):*

SECTION VI - ASSISTIVE DEVICES

6A. DOES THE VETERAN USE ANY ASSISTIVE DEVICES *(other than corrective shoes or orthotic inserts)* 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):*

Device				
☐ 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: ________	Frequency of use:	☐ Occasional	☐ Regular	☐ Constant

6B. IF THE VETERAN USES ANY ASSISTIVE DEVICES, SPECIFY THE CONDITION AND IDENTIFY THE ASSISTIVE DEVICE USED FOR EACH CONDITION:

SECTION VII - REMAINING EFFECTIVE FUNCTION OF THE EXTREMITIES

7. DUE TO THE VETERAN'S FLATFOOT CONDITION, 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 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 EXTREMITIES FOR WHICH THIS APPLIES:

☐ RIGHT LOWER ☐ LEFT LOWER

IDENTIFY THE CONDITION CAUSING LOSS OF FUNCTION, DESCRIBE LOSS OF EFFECTIVE FUNCTION AND PROVIDE SPECIFIC EXAMPLES *(brief summary):*

SECTION VIII - DIAGNOSTIC TESTING

NOTE - Plain or weight-bearing foot x-rays are not required to make the diagnosis of flatfoot. The diagnosis of degenerative arthritis *(osteoarthritis)* or traumatic arthritis must be confirmed by imaging studies. Once such arthritis has been documented, no further imaging studies are required by VA, even if arthritis has worsened.

8A. HAVE IMAGING STUDIES OF THE FOOT BEEN PERFORMED AND ARE THE RESULTS AVAILABLE?

☐ YES ☐ NO

IF YES, IS DEGENERATIVE OR TRAUMATIC ARTHRITIS DOCUMENTED?

☐ YES ☐ NO

IF YES, INDICATE FOOT: ☐ Right ☐ Left ☐ Both

8B. ARE THERE ANY OTHER SIGNIFICANT DIAGNOSTIC TEST FINDING AND/OR RESULTS?

☐ YES ☐ NO

IF YES, PROVIDE TYPE OF TEST OR PROCEDURE, DATE AND RESULTS *(brief summary):*

SECTION IX - FUNCTIONAL IMPACT

9. DOES THE VETERAN'S FLATFOOT CONDITION IMPACT HIS OR HER ABILITY TO WORK?

☐ YES ☐ NO IF YES, DESCRIBE THE IMPACT OF EACH OF THE VETERAN'S FLATFOOT CONDITIONS PROVIDING ONE OR MORE EXAMPLES:

SECTION X - REMARKS

10. REMARKS *(If any)*:

SECTION XI - PHYSICIAN'S CERTIFICATION AND SIGNATURE

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

11A. PHYSICIAN'S SIGNATURE	11B. PHYSICIAN'S PRINTED NAME	11C. DATE SIGNED

11D. PHYSICIAN'S PHONE AND FAX NUMBER	11E. PHYSICIAN'S MEDICAL LICENSE NUMBER	11F. 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 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 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.