SPONDYLOLISTHESIS / A LOWER-BACK GUIDE

Help your clinician see the day between visits.

Prepare for a useful conversation about back symptoms, movement and the activities that have changed. Use this guide with the care team you already have.

Start with what you know

Spondylolisthesis means one vertebra has slipped relative to the one below it. A symptom alone does not confirm that diagnosis. Bring the diagnosis and imaging report you have; ask your clinician what the findings mean for you.

A different question from slip grade

A scan describes structure. VA’s general spine formula considers measured motion, ankylosis and other specified findings, together with applicable functional-loss rules. The slip grade does not translate directly into a VA percentage.

What this guide helps you do

Describe your ordinary days and flares. Organize treatment and relevant records. Understand the lower-back rating branches. Ask for the next care step and correct factual errors in your record. Education cannot predict your individual rating.

01 / YOUR EXPERIENCE

Give the pattern. Then one real example.

Useful details explain what happens, how often it happens and what changes. You do not need to measure your own back angle.

Describe ordinary days and flares

Where do you feel symptoms? When did they begin? How often do symptoms worsen, how long does that last, and what seems to bring it on? Explain what your movement or activity is like during a flare compared with a usual day. Label estimates as estimates.

Show what you changed

Illustrative language — use only if true: “Yesterday I stopped loading the dishwasher after a few minutes. My partner finished. I sat down until the pain eased.” Add how often that occurs. A daily-life example is evidence of impact, not a percentage threshold.

Mention symptoms beyond back pain

Tell your clinician about leg pain, numbness, tingling, weakness or walking changes if present. Report what you observe without deciding which nerve or diagnosis explains it. Associated objective neurologic abnormalities may be evaluated separately by VA.

02 / CLINICAL FINDINGS

Your experience. Your clinician’s findings.

Both belong in the conversation. They are different kinds of information.

Movement is measured clinically

Forward flexion means bending forward. Combined range of motion adds six movements: forward bend, backward bend, both side bends and both rotations. The VA back questionnaire records motion, pain and functional impact. Do not push through pain or perform a home rating test.

Explain repeated use and flares

Describe what changes after repeated activity and during a flare, including frequency, duration and what you cannot do. A visit on a better day does not erase that history. The examiner considers available information when assessing additional functional loss.

A fixed region is different from stiffness

Ankylosis is fixation of a joint or region. The rating formula’s higher branches refer to the entire specified spinal region. Pain or stiffness alone is not enough. In some cases, functional loss during flares may amount to the functional equivalent of ankylosis; that requires an evidence-based assessment, not self-labelling.

03 / THE LOWER-BACK FORMULA

10% and 20%: alternative findings.

DC 5239 uses the General Rating Formula for Diseases and Injuries of the Spine. These are the thoracolumbar (mid- and lower-back) branches, not the neck criteria.

10% — any listed alternative

Forward flexion greater than 60° but no greater than 85°; OR combined motion greater than 120° but no greater than 235°; OR muscle spasm, guarding or localized tenderness without abnormal gait or abnormal spinal contour; OR a vertebral-body fracture with loss of at least 50% of height. The fracture clause is a general-formula alternative, not a usual feature of spondylolisthesis.

20% — any listed alternative

Forward flexion greater than 30° but no greater than 60°; OR combined motion no greater than 120°; OR muscle spasm or guarding severe enough to cause abnormal gait or abnormal spinal contour, such as scoliosis, reversed lordosis or abnormal kyphosis.

What the numbers mean

The forward-bend range and the combined-motion total are different measurements. “OR” matters: a qualifying alternative can apply without all the others. Guarding means protective restriction of movement; the required effect on walking or spinal contour distinguishes these branches.

04 / THE LOWER-BACK FORMULA

40%, 50% and 100%: which region is fixed?

The amount and type of fixation matter. These percentages are not labels for how painful an ordinary day feels.

40%

Forward flexion of the thoracolumbar spine 30° or less; OR favorable ankylosis of the entire thoracolumbar spine. Fixation in neutral position (0°) is always favorable under Note 5.

50%

Unfavorable ankylosis of the entire thoracolumbar spine. Note 5 requires fixation in flexion or extension plus at least one specified consequence: limited-line-of-vision walking difficulty; restricted mouth opening and chewing; breathing limited to diaphragmatic respiration; gastrointestinal symptoms from pressure of the costal margin on the abdomen; dyspnea or dysphagia; atlantoaxial or cervical subluxation or dislocation; or neurologic symptoms due to nerve-root stretching.

100%

Unfavorable ankylosis of the entire spine — this includes the neck, not only the lower back. There is no 30% or 60% rung in this lower-back general-formula sequence. Other codes or evaluation routes have their own requirements.

05 / PREPARE AND FOLLOW THROUGH

Leave with a clear next step.

Bring a short summary rather than trying to remember every detail during the visit.

Bring what you already have

Relevant visit notes and imaging reports; a medication list with your actual use; therapies, procedures or supports you have tried; what helped, what did not and concerning effects. Do not stop or change treatment to influence an examination.

Ask useful questions

“Do these symptoms need further evaluation?” “What should I do if the symptoms change?” “What is our treatment or follow-up plan?” “Does the note accurately reflect the examples I shared?” Your clinician determines which examination, imaging or referral is appropriate.

Check facts after the visit

Review available notes for accurate symptom history, medicines and reported daily limitations. If a fact is wrong, contact the care team with the specific correction. A clinical assessment may differ from your interpretation. New loss of bladder or bowel control, numbness around the groin or rapidly worsening weakness needs urgent medical evaluation.

06 / YOUR OBSERVATION PAGE

Your next example.

Print this page or copy the prompts into your own notes. Write what actually happened. Leave a detail blank if you do not know it.

When did it happen?

Date, approximate time and duration. Say if you are estimating.

What were you doing?

Name the activity and what symptoms you noticed.

What changed?

What did you stop, adjust or need help doing?

How often? What helped?

Usual pattern, flare pattern and response to your usual care.

What do you want to ask?

One question to bring to the appointment.

07 / SOURCES AND SCOPE

Read the source. Keep the scope clear.

Prepared September 22, 2026. This is general education for a provider conversation, not a diagnosis, individual legal advice or a promised VA result.

Rating and examination sources

38 CFR §4.71a, DC 5239 and the General Rating Formula, including Notes 1–6; §§4.40, 4.45 and 4.59 for applicable functional-loss and painful-motion principles. The VA Back (Thoracolumbar Spine) DBQ is version 24_4, updated December 20, 2024.

Interpretation and health information

Chavis v. McDonough (2021) addresses the functional equivalent of ankylosis in an appropriate case. NIAMS Back Pain provides clinical background and symptoms requiring prompt assessment. NHS Back Pain supports the urgent symptom guidance.

What remains individual

Service connection, the full record, applicable rules and VA adjudication determine the result. Associated objective neurologic abnormalities may receive separate evaluation under an appropriate code. This guide does not calculate a combined rating or substitute the IVDS incapacitating-episode formula.

38 CFR §4.71a — spine formula and notes

VA back examination questionnaire

Chavis v. McDonough — official opinion

NIAMS — Back Pain

NHS — Back pain: urgent symptoms

CONTROL THE FOUNDATION

Your health is where the evidence begins.

You cannot control the VA, the examiner or the timeline. You can take the next step toward having your conditions properly evaluated and your daily reality accurately documented.

Four paths. Only one brings both pieces together.

Wrong medicine. Wrong claim.

Gaps in the medical foundation and the claims process.

Wrong medicine. Right claim.

The right filing cannot fill gaps in the medical record.

Right medicine. Wrong claim.

The medical foundation is there, but is not put to work correctly.

Right medicine. Right claim.

Health evaluated. Findings documented. Evidence put to work.

Leave either piece incomplete and you risk a denial or a rating that does not reflect the conditions you live with. Start with your health. It is the foundation the claim depends on.

You can start with your care team. Or let us coordinate it.

VHN brings veteran-focused independent care, records, appointments and follow-up into one coordinated process. Your case manager keeps the moving pieces connected. Use your own accredited representative, or ask about an introduction.

SEE IF VHN IS RIGHT FOR YOU

Independent clinicians establish medical findings. Accredited representatives handle claims. The VA decides outcomes.