**SERVICE CONNECTED DISABILITY INTAKE FORM**

*Please answer* ***all*** *questions – if not applicable indicate “N/A”*

*If you are a veteran you may be entitled to veteran’s benefits. The following questions will help you and I organize the information you need to apply for benefits. If additional room is needed to complete an answer, please attach a separate piece of paper. Do NOT send this form to VA; bring it back to me.*

**NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NAME USED IN SERVICE IF DIFFERENT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number Street Apt No.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City State Zip Code**

* **Check here if mailing address is the same**

**MAILING ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Number Street Apt No.**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**City State Zip Code**

**TELEPHONE: ( ) \_\_\_\_\_ -\_\_\_\_\_\_\_\_\_\_ (Cell/Home/Work/Other:\_\_\_\_\_\_\_\_\_\_\_\_\_)**

**TELEPHONE: ( ) \_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_(Cell/Home/Work/Other: \_\_\_\_\_\_\_\_\_\_\_\_)**

**EMAIL ADDRESS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DATE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ PLACE OF BIRTH: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**County/State/Country**

**SOCIAL SECURITY NUMBER: \_\_\_\_\_-\_\_\_\_-\_\_\_\_\_\_\_**

**ARE YOU ( ) married ( ) Single ( ) Separated ( ) Divorced ( ) Widowed**

**HIGHEST LEVEL OF EDUCATION OBTAINED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ARE YOU CURRENTLY IN-SCHOOL? Y/N WHERE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**LIST ANY TRAINING CERTIFICATES, DEGREES, OR LICENSES YOU HAVE AND WHETHER THEY ARE CURRENT OR EXPIRED: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU HAVE ANY DEPENDENTS? Y/N IF YES, PLEASE LIST BELOW AND INDICATE RELATIONSHIP TO YOU:**

**NAME DOB RELATIONSHIP SSN**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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**ARE YOU CURRENTLY EMPLOYED? ( ) yes ( ) no**

**CURRENT OCCUPATION: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**IF NOT EMPLOYED, ARE YOU ABLE TO WORK? ( ) yes ( ) no**

**IF NOT EMPLOYED, IS IT BECAUSE OF MEDICAL PROBLEMS RELATED TO YOUR MILITARY SERVICE? ( ) yes ( ) no**

**ARE YOU RECEIVING SOCIAL SECURITY DISABILITY, SUPPLEMENTAL SOCIAL SECURITY, OR OTHER FORMS OF GOVERNMENT ASSISTANCE? Y/N TYPE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DO YOU HAVE A COPY OF YOUR DD 214? ( ) yes ( ) no**

**DID YOU SERVE ON ACTIVE DUTY?**

**WHAT BRANCH OF SERVICE DID YOU SERVE, DATES AND TYPE OF DISCHARGE:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_-\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_**

**REASON FOR DISCHARGE:**

**( ) COMPLETION OF OBLIGATION ( ) DOWNSIZING ( ) PHYSICAL DISABILITY ( ) OTHER**

**IF OTHER PLEASE SPECIFY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ARE YOU RECEIVING RETIREMENT PAY FROM THE MILITARY? Y/N AMOUNT: \_\_\_\_\_\_\_\_\_\_**

**ARE YOU RECEIVING DISABILITY PAY FROM THE MILITARY? Y/N AMOUNT: \_\_\_\_\_\_\_\_\_\_\_\_\_**

**DID YOU RECEIVE SEVERANCE PAY AT DISCHARGE? Y/N AMOUNT: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WERE YOU IN COMBAT? Y/N**

**WERE YOU WOUNDED? Y/N IF SO, WHERE ON THE BODY: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**ARE YOU STILL HAVING MEDICAL PROBLEMS CAUSED BY THE WOUND(S)/INJURY? Y/N**

**IF SO, WHAT ARE THE PROBLEMS: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**WERE YOU EVER A PRISONER OF WAR? Y/N IF YES, WHERE AND HOW LONG?**

**FOR PTSD CLAIMS:**

1. WERE YOU EXPOSED TO DEATH, THREATENED DEATH, ACTUAL OR THREATENED SERIOUS INJURY, OR ACTUAL OR THREATENED SEXUAL VIOLENCE (DIRECT, WITNESSING, RELATIVE/FRIEND WAS EXPOSED, DOING PROFESSIONAL DUTIES) Y/N
2. DO YOU PERSISTENTLY RE-EXPERIENCE A TRAUMATIC EVENT (INTRUSIVE THOUGHTS, NIGHTMARES, FLASHBACKS, EMOTIONAL DISTRESS AFTER REMINDERS, PHYSICAL REACTIVITY AFTER REMINDERS) Y/N
3. DO YOU AVOID TRAUMA-RELATED STIMULI (TRAUMA-RELATED THOUGHTS OR FEELINGS OR TRAUMA-RELATED REMINDERS) Y/N
4. DO YU HAVE NEGATIVE THOUGHTS OR FEELINGS THAT BEGAN OR WORSENED AFTER THE TRAUMA (INABILITY TO RECALL KEY FEATURES OF TRAUMA, OVERLY NEGATIVE THOUGHTS AND ASSUMPTIONS ABOUT ONESELF OR THE WORLD, EXAGGERATED BLAME OF SELF OR OTHERS FOR CAUSING TRAUMA, NEGATIVE AFFECT, DECREASED INTEREST IN ACTIVITIES, FEELING ISOLATED, DIFFICULTY EXPERIENCING POSITIVE AFFECT) Y/N
5. DO YOU HAVE TRAUMA-RELATED AROUSAL AND REACTIVITY THAT BEGAN OR WORSENED AFTER THE TRAUMA (IRRITABILITY OR AGGESSION, RISKY OR DESTRUCTIVE BEHAVIOR, HYPERVIGILANCE, HEIGHTENED STARTLE REACTION, DIFFICULTY CONCENTRATING, DIFFICULTY SLEEPING) Y/N
6. HAVE YOUR SYMPTOMS LASTED FOR MORE THAN 1 MONTH? Y/N
7. HAVE YOUR SYMPTOMS CREATED DISTRESS OR FUNCTIONAL IMPAIRMENT? (SOCIAL, OCCUPATIONAL, ETC) Y/N
8. ARE YOUR SYMPTOMS DUE TO MEDICATION, SUBSTANCE USE, OR OTHER ILLNESS? Y/N
9. IF YOU ARE EXPOSED TO TRAUMA-RELATED STIMULI DO YOU EXPERIENCE A FEELING OF BEING AN OUTSIDE OBSERVER OF OR DETACHED FROM ONESELF-LIKE BEING IN A DREAM OR EXPERIENCE UNREALITY, DISTANCE, OR DISTORTION-THINGS ARE NOT REAL: Y/N
10. DO YOU EXPERIENCE DELAYED SPECIFICATION (DIDN’T HAVE FULL DIAGNOSTIC CRITERIA UNTIL AT LEAST SIX MONTHS AFTER THE TRAUMA(S), ALTHOUGH ONSET OF SYMPTOMS MAY OCCUR IMMEDIATELY: Y/N

**ARE YOU RECEIVING COUNSELING THROUGH THE VET CENTER? Y/N WHEN/WHERE/COUNSELOR NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**FOR INDIVIDUAL UNEMPLOYABILITY:**

1. DO YOU HAVE SUBSTANTIAL EMPLOYMENT: Y/N
2. WHAT IS YOUR HOURLY OR ANNUAL SALARY? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. HAVE YOU EVER APPLIED FOR VOCATIONAL REHABILITATION AND EMPLOYMENT? Y/N
4. HAVE YOU BEEN EVALUATED BY VR&E? Y/N COUNSELOR: \_\_\_\_\_\_\_\_\_\_\_\_\_ WERE YOU FOUND ENTITLED? Y/N DATE: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
5. ARE YOU CURRENTLY UNEMPLOYED? Y/N
6. IS YOUR UNEMPLOYMENT DUE TO MEDICAL PROBLEMS RELATD TO MILITARY SERVICE? Y/N
7. ARE YOU ABLE TO OBTAIN AND MAINTAIN GAINFUL EMPLOYMENT? Y/N
8. WHAT IS YOUR HIGHEST LEVEL OF EDUCATION? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
9. WHERE WAS YOUR LAST EMPLOYMENT (WHERE, WHEN, JOB TITLE): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
10. ARE YOU RECEIVING SOCIAL SECURITY DISABILITY, SSI, OR OTHER ASSISTANCE? Y/N
11. DO YOU HAVE ONE SERVICE-CONNECTED DISABILITY RATED 60% +? Y/N
12. DO YOU HAVE TWO OR MORE SERVICE-CONNECTED DISABILITIES, WITH ONE RATED 40%+ AND COMBINED RATING OF 70%+? Y/N
13. DO YOU HAVE A MEDICAL OPINION THAT INDICATES YOU ARE UNABLE TO WORK BECAUSE OF YOUR SERVICE-CONNECTED DISABILITY? Y/N
14. DO YOU BELIEVE YOU ARE UNEMPLOYABLE DUE TO YOUR SERVICE-CONNECTED DISABILITY(S)? Y/N
15. DO YOU HAVE A PHYSICAL CONDITION THAT HAS CREATED A MENTAL HEALTH CONDITION SECORDARY (DEPRESSION/ANXIETY)? Y/N

**Have you ever applied for VA benefits? Y/N**

**Are you receiving VA benefits? Y/N If yes, check all that apply:**

**( ) Compensation ( ) Pension ( ) Home loan guaranty**

**( ) Medical care ( ) Education ( ) Vocational Rehabilitation**

**( ) Domiciliary care ( ) Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**At which VA Regional Office is your claim file located? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Were you ever treated at a VA Medical center or outpatient facility? Y/N**

**Please specify when, where, and what for: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**DID YOU BRING ANY SUPPORTING DOCUMENTS/EVIDENCE TO SUPPORT YOUR CLAIM TODAY? Y/N PLEASE LIST: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

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