Vet Center

PERSONAL INFORMATION

FULL NAME: *LAST* *FIRST* *MI*

SSN:

ADDRESS:

CITY/TOWN: STATE: ZIP:

HOME PHONE: MOBILE: WORK:

EMAIL:

DATE OF BIRTH: GENDER: ☐ Male ☐ Female

MARITAL STATUS: ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Never Married

ETHNICITY:
☐ White ☐ Pacific Islander/Hawaiian
☐ African American ☐ Native American
☐ Hispanic ☐ Alaskan Native
☐ Asian American ☐ No Response

MILITARY INFORMATION

MILITARY SERVICE:			*DEPLOYMENT INFORMATION:*
Branch of Service	*Deployment Start Date:*	*Deployment End Date:*	☐ *OEF* – Afghanistan
			☐ *OIF* – Iraq
			☐ *OND* – Operation New Dawn
			☐ Other
			NUMBER OF DEPLOYMENTS:

Wounded/Injured? ☐ Yes ☐ No | Purple Heart? ☐ Yes ☐ No | VA Service Connected? ☐ Yes ☐ No

FOR OFFICE USE ONLY	
DATE:	VIF NUMBER:
CLINICIAN'S NAME:	

On the next page are questions about your experience during and since deployment. These questions are simply to help us help you.

This questionnaire is only for the use of the Vet Center counselor and will not, unless legally required, be released to anyone without your written permission. Neither the National Guard nor any other government agency will have access to these questions unless you contact us and request release of this information.

When complete, please e-mail to: ng.ny.nyarng.mbx.family-programs@mail.mil

While you were deployed...	YES	NO
were you exposed to events that could be considered traumatic? (For example: firefights, explosions, casualties, sexual assault or harassment)		
when you were exposed to these events, did you feel afraid, helpless or horrified?		
were you ever exposed to hostile enemy fire (small arms fire, mortars, rockets, IEDs)?		
did you feel that you were personally in danger of being killed or seriously injured?		
did you feel you were in a safe area?		
Since your return home, have you ...		
felt anxious or upset when you think of things that happened in Iraq/ Afghanistan?		
tried to avoid thinking about some of the things you experienced in Afghanistan/Iraq?		
had times when you think or react as if you were still in the war zone?		
felt "on guard" or easily startled?		
had difficulty sleeping or experienced nightmares?		
had difficulty feeling close to friends and family?		
felt lonely or isolated from other people?		
had difficulty feeling positive about the future?		
memories or dreams of events that happened during deployment bother you?		
experienced any problems at home or with your family?		
taken any medication for anxiety or depression?		
been concerned that you may be using too much alcohol, prescription medication, or other substances to help you cope?		
have you sought any kind of counseling for thoughts or feelings that were bothering you?		
If so, who did you see and where?		
During the past two months, have you experienced any of the following?		
Increased stress, anxiety, or tension?		
Decreased appetite?		
Irritability or outbursts of anger?		
Feelings of worthlessness?		
Decreased interest in sex?		
Decreased interest or pleasure in doing things you used to enjoy?		
Feeling down, depressed, or hopeless?		
Thoughts of hurting or killing yourself or anyone else?		
Difficulty falling or staying asleep?		
Difficulty concentrating?		
Physical problems: (such as headaches, fever, feeling tired, dizziness, fainting, loss of energy, nervousness, chest tightness or pain, stomach or intestinal problems)?		

By signing your name below you authorize medical professionals with the Veterans Administration or their contractors to review this form and to provide an assessment or recommendation for additional counseling or assessment.

Signature	Date

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