



Organization Name:	Program Name:	Date:
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Individual's Name (First MI Last):	Record #:	DOB:
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Military Service History (Describe in comments section each element.)

When did you serve?	
What branch of the military did you serve?	<input type="checkbox"/> Army <input type="checkbox"/> Navy <input type="checkbox"/> Air Force <input type="checkbox"/> Marines <input type="checkbox"/> Coast Guard <input type="checkbox"/> Reserves/National Guard <input type="checkbox"/> Other:
Where did you serve?	
Are you still active?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
What job did (do) you have?	
If discharged, when and what type of discharge was received?	<input type="checkbox"/> Honorable <input type="checkbox"/> Dishonorable – Comments/Date:
Do you anticipate future deployment?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Have you been to the VA?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Have you contacted your local county Veteran Service Agency?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Do you have concerns that seeking help may impact your career?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Did you receive treatment for psychological distress while in the military?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:

Traumatic Brain Injury Screen (Describe in comments section each element.)
If "yes" to any of these questions, there may be a combat-related traumatic brain injury, seek professional assessment and treatment.

Have you been assessed for Traumatic Brain Injury?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
Do you avoid close contact with friends or family?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:

Have you experienced:

A vehicle accident (any type) or blast of any kind? An injury from a bullet, fragment, or shrapnel, etc.?
 Any injury that resulted in you feeling dazed or confused, not remembering the injury, loss of consciousness?
 Symptoms of concussion such as headaches, dizziness, irritability, light and noise sensitivity, or ringing in your ears?
 An injury to the head or face?

Comments:

Do you experience:

Difficulty with concentration and recall? Mood changes, depression, irritability or anxiety?

Comments:



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Military Trauma Screen (Describe in comments section each element.)

Have you ever been in a war-zone, fought in a war, or lived in a place where war was happening? Yes No -

If no, please skip to the next section, If Yes, Did you:

- Ever feel very afraid, horrified, or helpless? Ever think you might be seriously injured or killed?
- Ever witness someone being injured or killed? Lose any friends?
- Ever come under fire or have to return fire? Serve/Have you served in a leadership role in combat?
- Experience a hostage or POW situation? Experience torture or abuse?
- Have any difficulty managing your temper? Experience frequent feelings of survivor guilt or remorse?
- Startle response or flinch easily? Have triggers that bring on flashbacks(identify sounds, sights, smells)?
- Sleep with your weapons? Have difficulty falling asleep, staying asleep, or have frequent nightmares?
- Have difficulty driving? Have difficulty with your back to others, such as in a restaurant?
- Have you experienced tunnel vision, tunnel hearing, or events happening in slow motion during a high stress situation?
- Experience reliving of traumatic events, distressing recollections, or flashbacks?
- Use drugs or drinking to numb or ward off thoughts and feelings related to your experiences? *If yes, complete SA Assessment*

Comments:

Military Sexual Trauma Screen (Describe in comments section each element.)

While in the military, did you experience:

- Pressure to violate fraternization rules?
- Unwanted sexual attention, such as touching, cornering, pressure for sexual favors, or verbal remarks?
- Someone using force or threats of force or punishment to have sexual contact with you when you did not want to?

Comments:

Have you experienced changes in sexual functioning? Yes No - **Comments:**

Social Contracts (Describe in comments section each element selected.)

Have you experienced:

- An unexpected tour extension?
- Infidelity?
- Being disciplined, punished, mistreated or discriminated against while in the military?
- Having a lack of sufficient and effective equipment while you were in the service?
- Impact on your employment and/or your finances?
- Entitlement or benefit issues? *If yes, refer to local Veterans Service Agency*
- Shame related to seeking help?

Comments:



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In your opinion, was your service honored or rewarded? Yes No - Comments:

Community, Social Supports & Resiliency

Was coming home a difficult process?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Did you experience shame, humiliation or disrespect upon return to your community?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Have you or your family been relocated because of service?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Has your service impacted family and/or other relationships?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Are there negative emotions in the household or physical altercations?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Have your military experiences impacted your view of the world?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Do you engage in any wellness activities such as gym, sports, yoga, meditation, or massage?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Do you belong to the American Legion, VFW, or are involved in other community activities?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Are you utilizing the G.I. Bill to further your education?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Couples Not Applicable

Are there difficulties with intimacy or sexual functioning?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Are there known issues of infidelity or emotional separation?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Do you and your partner need skill building, problem solving or conflict resolution?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Children Not Applicable

Are there behavior problems in school or home?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Has the child witnessed or experienced uncontrollable outbursts?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Are there any difficulties with bonding, attachment or connection?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Were significant milestones missed or impacted (birthdays, graduations)?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Do the school social worker and teacher know the child is from a military family?	<input type="checkbox"/> Yes <input type="checkbox"/> No - Comments:
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Clinical Formulation		
Completed By - Print Name/Credentials:	Staff Signature:	Date:
Clinical Supervisor/ Professional Staff/ QHP/Team Leader - Print Name/Credentials (if needed):	Clinical Supervisor/ Professional Staff/ QHP/Team Leader - Print Name/Credentials (if needed):	Date: