PATHFINDERS
COUNSELING AND CONSULTING

VA RE-EVALUATION QUESTIONNAIRE

The information in this packet is confidential and protected under the privacy act of 1974.

Date: _____

I. Demographics:

Name (First, Middle Initial, Last):_____

Gender: ☐ Male ☐ Female Birth Date: _____ Age: _____

Race / Ethnic Ancestry:

☐ Asian ☐ Black ☐ Caucasian / White ☐ Hispanic / Latino(a)

☐ Native American / Alaskan ☐ Pacific Islander ☐ Other _____

Phone number: (_____)_____ Type: ☐ Work ☐ Home ☐ Cell May we leave a message? ☐ Yes ☐ No

Alternate phone number: (_____)_____ Type: ☐ Work ☐ Home ☐ Cell May we leave a message? ☐ Yes ☐ No

Email Address: _____ May we email you? ☐ Yes ☐ No

Please note: Email correspondence is not considered to be a confidential means of communication

Indicate the component(s) and service branch(es) that applied to you:

☐ Active Duty ☐ National Guard ☐ Reserves

☐ Air Force ☐ Army ☐ Coast Guard ☐ Marines ☐ Navy

Enlistment / Commission date: _____ Discharge date: _____

Type of Discharge: ☐ Retired ☐ Honorable Discharge ☐ Administrative Discharge ☐ Medical Discharge

Military Job / Duty Title: _____ Duties:_____

Rank at Discharge: _____ Highest Rank:_____ Total Time in Service: _____

What is your current VA Disability Rating? _____

For what condition(s): _____

When was your last VA Disability Evaluation (C&P): _____

II. Social/Marital/Family History Updates:

Since your last VA Disability Evaluation:

Have you had any difficulties creating or maintaining relationships with leadership/co-workers / other? ☐ Yes ☐ No

If yes, please explain: _____

_____

Have you had any difficulties creating or maintaining relationships with friends? □ Yes □ No

If yes, please explain: _____

_____

How many close friends do you have now? _____

How many times per month do you socialize with your friends? _____

What do you do when you spend time with your friends? _____

Please list the dates of your marriages and divorces that occurred **since your last VA Disability Evaluation**:

Marriage Date	Divorce Date	Number of Children	Reason for Divorce

How often do you argue with your current spouse / partner? _____

Overall, how would you describe your current marriage / romantic relationship **since your last VA Disability Evaluation**?
Check all that apply:

□ Happy □ Supportive □ Loving □ Unhappy □ Hostile □ Frightening □ Abusive
□ Other: _____

Do you have any children from a marital/non-marital relationship(s) **since your last VA Disability Evaluation**? □ Yes □ No

Describe your current relationship with your children? _____

_____

III. Occupational and Educational History

Since your last VA Disability Evaluation:

What level of education did you achieve **since your last VA Disability Evaluation**?

□ Obtained GED □ High school graduate □ Partial college □ Associates college degree
□ College graduate □ Graduate degree □ None, I have not gone to school

If applicable, how would you describe your academic performance **since your last VA Disability Evaluation**?

□ Excellent (A's and B's) □ Good (B's) □ High average (B's and C's) □ Average (C's) □ Poor (C's, D's, and F's)

If applicable, check all that applied to you during your schooling **since your last VA Disability Evaluation**:

□ No problems □ Difficulty concentrating □ Difficulty with teachers/staff
□ Academic problems □ Behavioral problems □ Learning disabilities

Were you employed **since your last VA Disability Evaluation:** □ Yes □ No

If yes, how many job(s) did you have: _____
Please briefly describe your job(s) / duties: _____

_____

Check all that applied during your employment **since your last VA Disability Evaluation**:

□ No problems □ With supervisors □ Difficulty following rules
□ With coworkers □ With customers □ Difficulty controlling temper

IV. Mental Health History:

Did you have any outpatient treatment or therapy **since your last VA Disability Evaluation**? □ Yes □ No

When were you treated and by whom: _____

What was the diagnosis? _____

Were you hospitalized in a psychiatric unit or psychiatric hospital **since your last VA Disability Evaluation**? □ Yes □ No

When and where: _____

Did you experience a head injury or traumatic brain injury **since your last VA Disability Evaluation**? □ Yes □ No

Describe: _____

Did you take psychiatric medications **since your last VA Disability Evaluation**? □ Yes □ No

Name or Type of Medication	Reason

Does anyone in your family-of-origin have any mental illness or an emotional difficulty (including alcohol/drug problems)? □ Yes □ No

Please specify: _____

Did you ever intentionally harm yourself without suicidal intent (e.g. cutting, burning, etc.) **since your last VA Disability Evaluation**? □ Yes □ No

If yes, how? _____

Did you ever have thoughts of suicide or self-harm **since your last VA Disability Evaluation**? □ Yes □ No

Did you ever have a specific plan or intend to hurt yourself **since your last VA Disability Evaluation**? □ Yes □ No

Did you ever have suicidal thoughts or attempt suicide **since your last VA Disability Evaluation**? □ Yes □ No

If yes, when and by what means: _____

_____

Did you have thoughts about homicide or hurting someone else **since your last VA Disability Evaluation**? □ Yes □ No

How would you describe your mental health functioning **since your last VA Disability Evaluation**:

□ I'm doing very well
□ Life's rough, but I get the job done
□ Life is a strain and I'm making minor, but noticeable errors
□ My mental health symptoms are preventing me from effectively working, socializing, or going to school, but I still try
□ I cannot leave the house or take care of myself because my mental health symptoms are so bad

V. Legal and Behavioral History:

Were you ever arrested **since your last VA Disability Evaluation**? ☐ Yes ☐ No

Were you ever on probation or parole **since your last VA Disability Evaluation**? ☐ Yes ☐ No

Charges/arrests **since your last VA Disability Evaluation** (please list reasons and ages): _____

_____

Did you have any behavioral problems that did not result in arrest **since your last VA Disability Evaluation**? ☐ Yes ☐ No

VI. Substance Use History

Did you use alcohol **since your last VA Disability Evaluation**? ☐ Yes ☐ No

On average, how often did you use alcohol **since your last VA Disability Evaluation**? _____

On average, how much did you drink at one time **since your last VA Disability Evaluation**? _____

What was your drink of choice when you drank **since your last VA Disability Evaluation**? _____

Did you use illicit / illegal drugs or misuse prescription medications **since your last VA Disability Evaluation**? ☐ Yes ☐ No

If yes, what type, how often, and how much did you use? _____

Did you receive substance abuse treatment **since your last VA Disability Evaluation**? ☐ Yes ☐ No

If yes, please list where you received treatment and when this occurred: _____

Did you use tobacco products **since your last VA Disability Evaluation**? ☐ Yes ☐ No

If yes, what type, how often, and how much did you use? _____

If yes, what type, how often, and how much did you use? _____

VII. Medical History:

Current medical problems, surgeries, or illnesses and date of onset:

_____

_____

Have you had chronic pain **since your last VA Disability Evaluation**? ☐ Yes ☐ No

Did you experience a head injury or traumatic brain injury **since your last VA Disability Evaluation**? ☐ Yes ☐ No
Describe: _____

Were you diagnosed with Traumatic Brain Injury **since your last VA Disability Evaluation**? ☐ Yes ☐ No

VIII. Current Symptoms / Problems:

Check all that have applied to you in **the past 30 days**:

□ Depressed mood	□ Risky behaviors	□ Abuse: Physical, Emotional, or Sexual
□ Loss of interest in activities	□ Gambling	□ Suspiciousness
□ Feelings of guilt	□ Increased self-esteem	□ Seeing people, animals, or things that others cannot see or say are not there
□ Low energy, tiredness	□ Decreased need for sleep / staying awake for several days	□ Hearing voices or noises that others cannot hear or say are not there
□ Poor concentration	□ Unusual increase in energy / activity □ Trauma	□ Feeling as if people are following you or watching you
□ Changes in appetite	□ Avoiding others	□ Paranoid thoughts
□ Weight gain (_____ lbs)	□ Repeated, unwanted thoughts / images	□ Problems in school or work
□ Weight loss (_____lbs)	□ Flashbacks: _____ per week / month	□ Problems with relationships
□ Difficulty falling asleep	□ Nightmares: _____ per week / month	□ Pending divorce or separation
□ Difficulty staying asleep	□ Memory problems	□ Financial problems
□ Unable to return to sleep	□ Panic or anxiety attacks:_____ per week	□ Extreme calorie restriction / counting
□ Decreased interest in sex	□ Anxiety in social or performance situations	□ Self-induced vomiting
□ Increased interest in sex	□ Uncontrollable impulses	□ Using laxatives to control weight
□ Grief/sense of loss	□ Health problems	□ Weighing yourself daily
□ Excessive worry	□ Chronic pain	□ Troubles eating or swallowing
□ Rapid mood swings	□ Repeated rituals (such as checking locks many times)	□ Fear of gaining weight
□ Irritability		
□ Frequent anger outbursts		
□ Racing thoughts		

XV. Military Service

Were you ever sexually assaulted **during your military service**? □ Yes □ No

Were you ever deployed to a combat zone? □ Yes □ No

Please provide date(s) of deployment(s), duration of tour (e.g., 12 months), and location below:

Start Date	End Date	Duration	Location

Did you receive incoming fire from small arms, mortars, or bombs? ☐ Yes ☐ No

At any point in your military service, did you experience anything that continues to cause nightmares / intrusive thoughts? ☐ Yes ☐ No

If yes, **BRIEFLY** describe the disturbing thing(s) that happened to you during your military service that still bothers you:

_____

_____

_____

During the event(s):

- Were you physically injured? ☐ Yes ☐ No
- Was someone else physically injured? ☐ Yes ☐ No
- Did you think your life was in danger? ☐ Yes ☐ No
- Did you think that someone else's life was in danger? ☐ Yes ☐ No

How did you respond emotionally DURING or AFTER the disturbing event(s)? Please circle all that apply.

Horror	Excited	Terror	Confused	Helpless	Shame
Fear	Sadness	Grief	Guilt	Other feelings: _____	