



**DEPARTMENT OF VETERANS AFFAIRS**  
**Sioux Falls VA Health Care System**  
**PO Box 5046, 2501 West 22<sup>nd</sup> Street**  
**Sioux Falls, South Dakota 57117**

**Please fill out the information as completely as possible.**

Name: \_\_\_\_\_ SSN: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_ City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ May we leave a message:  Yes  No

If No, How may we contact you: \_\_\_\_\_

Sex: M F Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_

I understand my report will become part of my VA electronic medical record and can be accessed by my health/mental health providers.

\_\_\_\_\_  
Veteran or Guardian signature

\_\_\_\_\_  
Date

**Please describe the reason for your visit and/or what you are hoping to gain as a result of therapy:**

Referral source:

**History of Current Problem:**

Please describe your current symptoms of emotional distress:

When did these symptoms start?

What may have caused these symptoms to onset/start?

**Military Service:**

With what branch of the military did you serve? \_\_\_\_\_

What drew you into the military?

What years did you serve? \_\_\_\_\_

Please list any deployments and dates of deployment:

Were you ever in combat? Yes No  
 If yes, please describe:

What were your jobs/duties?

Were there ever any issues raised by the military (for example, demotion, Article 15, court martial, Captain's Mast, failed drug screen)? Yes No  
 If yes, please describe:

Were you ever turned down for military service/reenlistment? Yes No  
 If yes, please describe:

Do you have any physical or mental health problems related to your time in the service? Yes No  
 If yes, please describe:

Type of discharge? \_\_\_\_\_  
 Rank at time of discharge? \_\_\_\_\_  
 Reason for discharge? \_\_\_\_\_

**Physical Health:**

Please rate your overall physical health. (Please circle) Poor Fair Good Very good Excellent

What medications are you taking? \_\_\_\_\_

Please list any medications not prescribed by VA. \_\_\_\_\_

Please check any of the following that you or a family member have had difficulties with:

	<u>You</u>	<u>Family Member</u>
High Blood Pressure.....	_____	_____
Diabetes.....	_____	_____
High Cholesterol.....	_____	_____
Heart Problems.....	_____	_____
Cancer.....	_____	_____
Kidney Problems.....	_____	_____
Liver Disease.....	_____	_____
Respiratory Problems.....	_____	_____
Alzheimer's or other memory difficulty.....	_____	_____
Huntington's disease.....	_____	_____
Parkinson's disease.....	_____	_____
Seizures (epilepsy).....	_____	_____

HIV or AIDS.....	_____	_____
Multiple Sclerosis.....	_____	_____
Lupus.....	_____	_____
Rheumatoid Arthritis.....	_____	_____
Stroke.....	_____	_____
Thyroid difficulties.....	_____	_____
Other(s) (please specify)_____.....	_____	_____

Any surgeries, major illnesses, or major injuries? Yes No  
 If yes, please describe:

Any concerns about your vision or hearing? Yes No  
 If yes, please describe:

Do you have any medical concerns that have not been addressed by a physician? Yes No  
 If yes, please describe:

Is your medical condition affecting your emotional condition? Yes No  
 If yes, please describe:

Were there any problems or complications when you were born? Yes No  
 If yes, please describe:

Any difficulty learning to walk, talk, or meeting other developmental milestones? Yes No  
 If yes, please describe:

**Pain Assessment/Care:**

Do you have chronic pain anywhere/tingling/numbness? Yes No  
 If yes, how long have you had the chronic pain?  
 When did it start?  
 Describe the cause/injury?  
 Current treatment:  
 What types of treatments have you tried?

Do you have problems with headaches? Yes No  
 If yes, please describe:  
 What types of treatment?

**Nutrition:**

Are you on a special diet? Yes No  
 If yes, please describe:

Do you have problems chewing or swallowing food or liquids? Yes No  
 If yes, please describe:

Has your weight changed more than 10 pounds in the past month? Yes No  
 If yes, please describe:

Would you like to talk with a clinician about nutritional concerns? Yes No

If yes, please describe:

How many meals a day are you eating?\_\_\_\_\_

What kind of meals are they (for example, fast food, microwave, home cooked, mission, packaged foods)?\_\_\_\_\_

**Head Injury:**

Have you ever had a head injury or been knocked unconscious? Yes No

If yes, please describe:

When did this happen?

How long were you unconscious?

What rehabilitation have you had?

Describe any lasting effects:

**Mental Health:**

Have you ever been diagnosed with or treated for any psychological or emotional difficulties (for example, involved in therapy, taken prescribed medication)?

Yes No

If yes, please describe when, where, and if helpful:

Have you ever been hospitalized for mental health problems? Yes No

If yes, please describe:

**Mental Health Screen:**

Please check any of the following that you or a family member have experienced:

	<u>You</u>	<u>Family Member</u>
Depression.....	_____	_____
Anxiety.....	_____	_____
Obsessive Compulsive Disorder.....	_____	_____
Panic Disorder.....	_____	_____
Bipolar disorder (manic-depression).....	_____	_____
Schizophrenia.....	_____	_____
Alcohol/drug use problems.....	_____	_____
Eating disorder (e.g., anorexia, bulimia, binge eating)...	_____	_____
Post Traumatic Stress Disorder (PTSD).....	_____	_____
Attention Deficit Disorder.....	_____	_____
Other (please specify)_____.....	_____	_____
Other (please specify)_____.....	_____	_____

Have you noticed any recent changes in your mood or personality? Yes No

If yes, please describe:

Do you have difficulties with anger or irritability? Yes No

If yes, please describe:

Are you having any mood swings? Yes No

If yes, please describe:

Ever get in trouble for your behavior? Yes No

If yes, please describe:

Do you hear or see unusual things that others do not? Yes No  
If yes, please describe:

Do you have any problems with weight or appetite? Yes No  
If yes, please describe:

Do you have any problems or concerns with sexual functioning? Yes No  
If yes, please describe:

Do you have any problems with your energy level? Yes No  
If yes, please describe:

What time do you go to sleep at night? \_\_\_\_\_

What time do you get up in the morning? \_\_\_\_\_

How many days per week do you take naps? \_\_\_\_\_

Please circle any of the following problems you are currently experiencing:

Difficulty falling asleep	Nightmares
Difficulty staying asleep	Difficulty staying awake during the day
Waking up too early	Difficulty staying awake while driving
Difficulty getting up in the morning	Feeling constantly tired
Severe snoring	Sleep walking
Others have said you stop breathing while sleeping	

Do your relationships with others tend to be (please circle all that apply):

Want one, but it's difficult/awkward	Intense/too close	Avoidant/too distant
Would rather be alone	Healthy	Competitive
Variable	Suspicious	Emotional

Do you have any problems with attention/concentration? Yes No  
If yes, please describe:

Do you have any problems with memory? Yes No  
If yes, please describe:

Do you have any problems performing your own hygiene needs (for example, bathing, dressing yourself, toileting)? Yes No  
If yes, please describe:

Do you have any problems driving? Yes No  
If yes, please describe:

Do you need help with chores (for example, cleaning, cooking, keeping track of medications, managing finances)? Yes No  
If yes, please describe:

**Trauma (military and non-military):**

Have you ever been forced or pressured into sex or been touched in a sexual way that made you uncomfortable? Yes No  
If yes, please describe:

Have you ever experienced physical assault/abuse? Yes No  
If yes, please describe:

Have you ever experienced emotional assault/abuse? Yes No  
If yes, please describe:

Any time you feared for your life or thought you were going to be killed? Yes No  
If yes, please describe:

Ever witnessed anyone else being killed? Yes No  
If yes, please describe:

Check any of the following that you experienced (childhood or adulthood):

- |  |  |
|--|--|
| <input type="checkbox"/> Witness of domestic abuse                                   | <input type="checkbox"/> Severe stressor   |
| <input type="checkbox"/> Death of a family member or close friend                    | <input type="checkbox"/> Natural disaster  |
| <input type="checkbox"/> Community violence  | <input type="checkbox"/> Fire or explosion |
| <input type="checkbox"/> Captivity (for example, being kidnapped, held hostage, POW) |  |
| <input type="checkbox"/> Life threatening illness or injury                          | <input type="checkbox"/> Other             |

If yes, please describe:

#### **Self/Other Harm:**

Have you ever had thoughts of hurting yourself or ending your life? Yes No  
If yes, please describe:

Have you ever intentionally overdosed on medications or drugs? Yes No  
If yes, please describe:

Have you ever intentionally cut, burned, or disfigured yourself? Yes No  
If yes, please describe:

Has any family/friend attempted or completed suicide? Yes No  
If yes, please describe:

Have you ever had thoughts of hurting another person or ending another person's life? Yes No  
If yes, please describe:

#### **Alcohol Use History:**

Do you use alcohol? Yes No

If yes, how often do you drink on average?

How much do you drink on average in one sitting?

What is your pattern of drinking (for example, continuous, binge, alone, social)?

Age of first usage?

Last usage?

Period of heaviest use?

Use over the past 12 months?

Do you find yourself drinking when you do not want to? Yes No  
If yes, please describe:

Has drinking ever caused you any problems (for example, marital, job-related, financial, physical, family/friends, emotional, blackouts, memory)? Yes No  
 If yes, please describe:

Have you ever had alcohol treatment in the past? Yes No  
 If yes, please describe when, where, and outcome:  
 Are there any changes to alcohol treatment that you feel would increase your likelihood of success?

### **Substance Use History:**

Have you ever gotten high, abused, or experimented with other drugs/substances (for example, marijuana, cocaine, meth, heroin, mushrooms, inhalants, steroids, prescription pain medication)? Yes No  
 If yes, please indicate substance(s) and when:

How often do you use on average?  
 How much do you use on average in one sitting?  
 What is your pattern of usage (for example, continuous, binge, alone, social)?  
 Age of first usage?  
 Last usage?  
 Period of heaviest use?  
 Use over the past 12 months?

Has substance use ever caused you any problems (for example, marital, job-related, financial, physical, family/friends, emotional, blackouts, memory)? Yes No  
 If yes, please describe:

Have you ever been in treatment for drug use? Yes No  
 If yes, please describe when, where, and outcome:  
 Are there any changes to substance use treatment that you feel would increase your likelihood of success?

Do you drink coffee, cola, or other sources of caffeine? Yes No  
 How much?  
 How often?

### **Tobacco Use History:**

Do you use tobacco? Yes No  
 If yes, what type (for example, cigarettes, cigars, chew, snuff)?  
 How much?  
 How long have you used?  
 Have you tried to quit in the past?  
 Are you interested in quitting now?

If you do not use tobacco, have you ever used it regularly? Yes No  
 If yes, how long ago did you quit?

**Gambling/Gaming History:**

Do you gamble? Yes No

If yes, what type (for example, casino, Internet, bar, friend's home):

How often:

Do you want therapy/help for gambling?

Do you video game? Yes No

If yes, how many days per week?

How long on average at a time?

Have you ever spent money on gambling that was needed for other things? Yes No

If yes, please describe:

Have you ever felt guilt or remorse about gambling? Yes No

If yes, please describe:

**Family History:**

Where were you born? \_\_\_\_\_

Where did you grow up? \_\_\_\_\_

Who raised you? \_\_\_\_\_

Please list your brothers, sisters, and their current ages (if deceased, then list age at death)

Person	Relationship (Full, half, step)	Birth order (oldest, 2 <sup>nd</sup> , 3 <sup>rd</sup> , etc.)	Currently living or deceased	Current age or age at time of death
Brother/Sister			Living/deceased	

Please describe what it was like living in your home as a child:

Were your parents ever divorced or separated? Yes No

If yes, please describe:

Is your father still living? Yes No

How old is he now or, if deceased, how old was he when he died? \_\_\_\_\_

If deceased, what was the cause of death?

Is your mother still living? Yes No

How old is she now or, if deceased, how old was she when she died? \_\_\_\_\_

If deceased, what was the cause of death?

Please describe your current relationships with your parents and siblings:

Were you punished as a child? Yes No

If yes, please describe:



Type of residence/abode:

House  Apartment  Townhouse  Nursing home  Assisted living  Car  Streets  
 Other (please describe)

Who is currently living in your residence? \_\_\_\_\_

How long have you been living at your current address? \_\_\_\_\_

If less than three years, where else have you lived in the last three years and how long at each place?

Is your living situation stable? Yes No

If no, please describe the reason and any changes you foresee:

Do you wish to speak with someone regarding your housing concerns? Yes No

### Transportation:

What transportation(s) do you use?

Car  Walking  Bus  Rideshare with a driver  Family/friend drives me  Other

Any problems or concerns with transportation? Yes No

If yes, please describe:

### Sexuality:

Are you experiencing any problems or concerns with your current sexual life/performance? Yes No

If yes, please describe:

What is your sexual partner preference?  Male  Female  Both

Are you sexually active? Yes No

If yes, with how many partners?

Have you ever experienced miscarriage? Yes No N/A

If yes, please describe:

Have you ever forced anyone into a sexual act against their will? Yes No

If yes, please describe:

### Cultural History:

With what race and/or ethnic group(s) do you identify (for example, Black/African American, Native American, White/Caucasian, Hispanic, Asian, Pacific Islander, Irish, Norwegian, Cuban, Australian, Kenyan)? \_\_\_\_\_

With what peer group do you most identify (for example, white collar worker, blue collar worker, motorcyclist, hippie, partier, cultural, academic, gang, athlete)? \_\_\_\_\_

Do you have any concerns about discrimination? Yes No

If yes, please describe:

Do you have any cultural/ethnic concerns that may impact treatment? Yes No

If yes, please describe:

**Spirituality:**

Is spirituality something that is important to you? Yes No  
 If yes, please describe:

Do you belong to a religious/spiritual group? Yes No  
 If yes, please describe:

In what spiritual activities do you engage (for example, prayer, sweat lodge, meditation, pilgrimage)?

Do you have any concerns with your current level of spirituality? Yes No  
 If yes, please describe:

Do you have any spiritual concerns that may impact treatment? Yes No  
 If yes, please describe:

Would you like a referral to the Chaplain Service? Yes No

**School/Education:**

Where did you go to school? \_\_\_\_\_  
 What was the highest grade you completed? \_\_\_\_\_  
 If you did not complete high school, please explain the reason:  
 If you did not complete high school, did you obtain a GED?

Did you require any special education classes or extra assistance? Yes No  
 If yes, please describe:

How would you describe:  
 School/grades (as a youth):      very good      good      average      marginal      poor  
 General attitude (as a youth):      very good      good      average      marginal      poor

Please describe your social interactions as a youth (friends, dating, hobbies, sports):

Did you have any history of trouble as a youth (example: expelled, suspended, placed on academic probation)? Yes No  
 If yes, please describe:

If you attended any college or trade school, please complete the following:

College/Trade School	Degree obtained	Major	Date of degree

Are you planning on going to school in the future? Yes No  
 If yes, when?  
 What major/career are you planning on pursuing?  
 Where are you planning to attend?  
 What, if any, obstacles or concerns do you foresee?

**Current Employment Status/Employment History:**

Where do you get your primary financial support?

Current status:

- Full-Time Student       Part-Time Student       Homemaker  
 Disabled                       Full-Time Employed       Part-Time Employed  
 Limited Employment       Retired                       Unemployed

If you are not currently employed, what is the reason you are not currently employed?

If you are not currently working, do you plan to return to work at anytime in the future?

If you are presently employed, who is your employer? \_\_\_\_\_

How long have you worked there? \_\_\_\_\_

Please describe your job duties/position: \_\_\_\_\_

Please list any concerns with your current working situation:

If you are currently disabled, please indicate how long you have been disabled and the reason for the disability.

If you are retired, how long have you been retired?

Please list all past employment (beginning with your most recent job):

Employer	Job Title	Start Date	End Date	Reason for Leaving

Do you feel your current financial situation is stable?                      Yes    No  
 If no, what changes do you foresee?

Are money and bill paying big concerns for you right now?            Yes    No  
 If yes, is it putting stress on your relationships?

What sources of debt do you have (for example, credit card, payday loan, student loan, title loan, child support, personal loan):

Do you wish to talk to someone regarding financial concerns?        Yes    No

**Legal History:**

Have you ever been in prison or jail?    Yes    No  
 If yes, please describe where and when:

Are you currently on probation or parole?                                    Yes    No  
 If yes, please describe:

Have you ever registered as a sex offender?                                Yes    No  
 If yes, please explain:

Please list convictions or arrests you have had.

Arrest Date	Charge(s)	Where (City or State)	Were you convicted?	Length of time in prison/jail

Have you been involved in any lawsuits as either a plaintiff or defendant, or are any pending? Yes No  
 If yes, please explain:

Has anyone ever gotten a restraining order against you? Yes No  
 If yes, please explain:

Have you ever gotten a restraining order against someone else? Yes No  
 If yes, please explain:

Any other legal concerns right now (for example, divorce, child support, child custody, bankruptcy)? Yes No  
 If yes, please explain:

Do you need proof of treatment? Yes No  
 If yes, please explain:

**Community Resources:**

Do you use any of the following community resources (for example, food stamps, heating/rental assistance, food pantry, shelter, churches, gyms, Vet Center, VFW)? Yes No  
 If yes, please describe:

**Recreation/activity:**

What sorts of things do you do to keep busy?

What are your hobbies/interests?

Any significant changes in recreation/activity (for reasons such as: health, legal, lifestyle changes)? Yes No  
 If yes, please describe:

Do you have enough time for leisure activities? Yes No

Do you feel that you suffer from being bored? Yes No  
 If yes, please describe:

What are your strengths?

**Please discuss any other concerns not asked about:**