Organization Name:	**Program Name:**	**Date:**
Individual's Name (First MI Last):	**Record #:**	**DOB:**

Military Service History (Describe in comments section each element.)	
When did you serve?	
What branch of the military did you serve?	☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Coast Guard ☐ Reserves/National Guard ☐ Other:
Where did you serve?	
Are you still active?	☐ Yes ☐ No - Comments:
What job did (do) you have?	
If discharged, when and what type of discharge was received?	☐ Honorable ☐ Dishonorable – Comments/Date:
Do you anticipate future deployment?	☐ Yes ☐ No - Comments:
Have you been to the VA?	☐ Yes ☐ No - Comments:
Have you contacted your local county Veteran Service Agency?	☐ Yes ☐ No - Comments:
Do you have concerns that seeking help may impact your career?	☐ Yes ☐ No - Comments:
Did you receive treatment for psychological distress while in the military?	☐ Yes ☐ 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?	☐ Yes ☐ No - Comments:
Do you avoid close contact with friends or family?	☐ Yes ☐ 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?	☐ Yes ☐ No - Comments:
Did you experience shame, humiliation or disrespect upon return to your community?	☐ Yes ☐ No - Comments:
Have you or your family been relocated because of service?	☐ Yes ☐ No - Comments:
Has your service impacted family and/or other relationships?	☐ Yes ☐ No - Comments:
Are there negative emotions in the household or physical altercations?	☐ Yes ☐ No - Comments:
Have your military experiences impacted your view of the world?	☐ Yes ☐ No - Comments:
Do you engage in any wellness activities such as gym, sports, yoga, meditation, or massage?	☐ Yes ☐ No - Comments:
Do you belong to the American Legion, VFW, or are involved in other community activities?	☐ Yes ☐ No - Comments:
Are you utilizing the G.I. Bill to further your education?	☐ Yes ☐ No - Comments:
Couples ☐ Not Applicable	
Are there difficulties with intimacy or sexual functioning?	☐ Yes ☐ No - Comments:
Are there known issues of infidelity or emotional separation?	☐ Yes ☐ No - Comments:
Do you and your partner need skill building, problem solving or conflict resolution?	☐ Yes ☐ No - Comments:
Children ☐ Not Applicable	
Are there behavior problems in school or home?	☐ Yes ☐ No - Comments:
Has the child witnessed or experienced uncontrollable outbursts?	☐ Yes ☐ No - Comments:
Are there any difficulties with bonding, attachment or connection?	☐ Yes ☐ No - Comments:
Were significant milestones missed or impacted (birthdays, graduations)?	☐ Yes ☐ No - Comments:
Do the school social worker and teacher know the child is from a military family?	☐ Yes ☐ 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:**