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

Military Service History	
Who is or has been in the US Armed forces?	
When did the service member serve?	
What military branch?	☐ Army ☐ Navy ☐ Air Force ☐ Marines ☐ Coast Guard ☐ Reserves/National Guard Other:
What was/is their job in the military?	
Has the service member registered at the VA?	☐ Yes ☐ No - Comments:
Have there been challenges around benefits or entitlements*? If so, refer to the local Veterans Service Agency*	☐ Yes ☐ No - Comments:
Is the service member currently deployed?	☐ Yes ☐ No - Comments:
If so, when is the anticipated date of return?	
Is deployment pending or imminent?	☐ Yes ☐ No - Comments:
How many deployments have occurred and for what duration?	
Has anyone in your family sought treatment for psychological distress related to military services?	☐ Yes ☐ No - Comments:

Military Family/Significant Other Screen	
Do you have concerns around seeking help or impact on the service members' career?	☐ Yes ☐ No - Comments:
Describe the impact deployment or service has had on you and/or the family (emotional/physical).	☐ Yes ☐ No - Comments:
Has the family relocated because of service?	☐ Yes ☐ No - Comments:
Does the service member or family members have difficulty with mood changes, depression, irritability or anger management?	☐ Yes ☐ No - Comments:
Is there any violence at home (e.g., anyone being hit)?	☐ Yes ☐ No - Comments:
Are there any difficulties with renegotiating roles and tasks?	☐ Yes ☐ No - Comments:
Did you ever think that your loved one could be seriously injured or killed?	☐ Yes ☐ No - Comments:
Does the service member or family members know anyone that was seriously injured or killed?	☐ Yes ☐ No - Comments:
Did the service member share stories or did others overhear statements involving death or serious injuries?	☐ Yes ☐ No - Comments:
Is the service member or significant other experiencing flashbacks or reliving of traumatic events?	☐ Yes ☐ No - Comments:
Are there known triggers *(identify sights, sounds, smells, situations)* that the service member or others identified?	☐ Yes ☐ No - Comments:
Is there any screaming during the night due to nightmares or difficulty coping?	☐ Yes ☐ No - Comments:
Is anyone in the household experiencing frequent thoughts of death, suicide or homicide?	☐ Yes ☐ No - Comments:
Does the service member or others sleep with weapons?	☐ Yes ☐ No - Comments:

Individual's Name (First MI Last):	**DOB:**
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 with 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:
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:**