AFRICAN AMERICAN PTSD ASSOCIATION
9129 Veterans DR SW
Lakewood, WA 98498
Ph: (253) 589-0766 // Fax: (253) 589-0769

PRE-SCREENING QUESTIONAIRRE

NAME: LAST, FIRST, MIDDLE	**DOB:** (MM/DD/YY)
ADDRESS:	**CONTACT TELEPHONE:**
1) Do you have an open claim with any other veteran organization? **YES** ☐ **NO** ☐	**DATE(S) OF MILITARY SERVICE/BRANCH:**
2) What was the last organization you put in a claim with? List name and location of the organization.	3) What records or documents do you have in your possession? DD214 ☐ Military Medical ☐ Civilian Medical ☐ Social Security ☐ Other ☐
4) Are you a wartime Veteran? **YES** ☐ **NO** ☐ If yes, please indicate which era: WWI ☐ WWII ☐ VIETNAM ☐ PANAMA ☐ GULF ☐ IRAQ ☐	

PTSD
(Post Traumatic Stress Disorder)

Post Traumatic Stress Disorder is a term used to explain the distress of those who have gone through such an extra ordinary and stressful event(s) in their lives that is has left them psychologically wounded. Generally, individuals with PTSD experience intense fear, helplessness, or horror during trauma exposure. The trauma of military service in war such as being under enemy fire or ambushed; very hazardous duty such as being a team member in reconnaissance aircrafts, patrol boats, and ships or cargo and transport trucks is one such cause. Being on frequent or prolonged combat missions in enemy territory (including Cambodia and Laos), being attacked by sappers, snipers, artillery or rockets are just a few other examples. The witnessing of death and terrible harm to your own body or the bodies of others; or walking point, being a radio operator, a medic, a scout, a tunnel rat, and a perimeter sentry are other examples. Moreover, PTSD is not limited to trauma due to a combat experience; or it could be any traumatic experience that has prolonged effects on your mental and physical health that is linked to military service.

NOTE: One must be properly diagnosed with PTSD by a mental health professional in order to submit a claim through the Veterans Administration for this condition. Please answer the following questions:

5) Have you ever put in a claim for PTSD? **YES** ☐ **NO** ☐
6) Are you presently in treatment for PTSD? **YES** ☐ **NO** ☐
7) Have you ever been diagnosed with PTSD? **YES** ☐ **NO** ☐

8) If you answered yes to question #7, please give us the dates of (time span) treatment, mental health provider or organization, treatment received, and any medication subscribed if applicable.

READ: You may be eligible for compensation for injuries or illnesses you suffer as a result of active duty or for any you had before service that were made worse because of your active duty service. However, in order to submit a claim through the Veterans Administration, a claim must be well grounded. A claim is well grounded if you have sought treatment or diagnoses for this conditions treatment history for this condition to validate your claim.

In order to better evaluate and asses your well grounded claim, it is important that we gather as much information as possible about your condition. We ask that you answer the following questions for each condition:

Condition 1:

1) State the condition (onset date, how long it lasted, military treatment):

2) Rate the severity of the condition: Mild □ / Moderate □ / Severe □

3) Medication, whether prescribed by a physician or over the counter:

4) Are you receiving compensation for this condition? Yes □ Percentage _____% / No □

Condition 2:

1) State the condition (onset date, how long it lasted, military treatment):

2) Rate the severity of the condition: Mild □ / Moderate □ / Severe □

3) Medication, whether prescribed by a physician or over the counter:

4) Are you receiving compensation for this condition? Yes □ Percentage _____% / No □

Condition 3:

1) State the condition (onset date, how long it lasted, military treatment):

2) Rate the severity of the condition: Mild □ / Moderate □ / Severe □

3) Medication, whether prescribed by a physician or over the counter:

4) Are you receiving compensation for this condition? Yes □ Percentage _____% / No □

Condition 4:

1) State the condition (onset date, how long it lasted, military treatment):

2) Rate the severity of the condition: Mild □ / Moderate □ / Severe □

3) Medication, whether prescribed by a physician or over the counter:

4) Are you receiving compensation for this condition? Yes □ Percentage _____% / No □

_____	_____
Client Signature	VSO Signature
____/____/____	____/____/____
Date	Date