Separation Health Assessment Part A Self-Assessment

Supplemental Guidance for Service Members

The following guidance is intended for Service members completing the SHA Self-Assessment (Part A of DD Form 3146 or the VA SHA DBQ) in electronic or print format.

Contents

TABLE OF ACRONYMS

ACRONYM	DESCRIPTION
AD	Active Duty
AHOBPR	Airborne Hazards and Open Burn Pit Registry
AFSC	Air Force Specialty Code
AOC	Area of Concentration
BDD	Benefits Delivery at Discharge
C-section	Cesarean Section
COPD	Chronic Obstructive Pulmonary Disease
CPAP	Continuous Positive Airway Pressure Therapy
DBQ	Disability Benefits Questionnaire
DoB	Date of Birth
DoD	Department of Defense
EHR	Electronic Health Record
FDC	Fully Developed Claim
HIV	Human Immunodeficiency Virus
HPV	Human Papilloma Virus
ID	Identification
IDES	Integrated Disability Evaluation System
IUD	Intrauterine Device
LEEP	Loop Electrosurgical Excision Procedure
MOS	Military Occupational Specialty
NEC	Naval Enlistment Code
Pap	Papanicolaou test
PCOS	Polycystic Ovarian Syndrome
PRK	Photorefractive keratectomy
PTSD	Post-Traumatic Stress Disorder
SHA	Separation Health Assessment
SSN	Social Security Number
TBI	Traumatic Brain Injury
VA	Department of Veterans Affairs
TMD	Temporomandibular Disorder
TMJ	Temporomandibular Joint

SHA Part A – Self-Assessment

To be completed by the Service member.

Section I. Identification

Answer all questions to the best of your ability.

A.I.1 Contact Information

Please ensure that valid contact information is provided so you can be reached for scheduling of any necessary examinations, tests, or follow-up communication. If you are planning to move, make sure you provide a cell phone number and personal email where you can be reached before, during, and after your move.

A.I.2 Personal Information

Answer all questions to the best of your ability.

A.I.3 Occupational Information

Q4. Usual Occupation: This refers to your job or duties performed during the most recent period of military service. Please note if your usual occupation is different than your military occupational specialty and for how long you were performing the duties of each.

A.I.4 Examination Information

Q1. Examination Date: This refers to the date you are scheduled for your in-person (face-to-face) physical examination. Leave blank if not known.

Q3. Release from Active Duty date:

- If you are a member of an active duty component, please provide the date you expect to separate from the active duty component.
- If you are a member of a reserve component who is (a) separating from active duty orders and then (b) retiring, being discharged or dismissed from the armed forces, or submitting a BDD claim to VA, please provide the end date of your active duty orders.
- If you do not know or cannot recall a specific date, then please provide an estimated date.

Q4. Claim for Disability Compensation: Select "yes" if you plan to file, or have already filed, a disability compensation claim with VA. Do not count claims for any other VA benefits you are currently receiving or have already received, such as VA Loans or Post-9/11 GI Bill.

Q5. Type of Claim Program/Process: If you selected "yes" in Q4, indicate the type of planned or pending disability compensation claim (if you know):

- **Fully Developed Claim (FDC) Program** is a VA process that allows you to file a claim within 90 days of release from active duty. The FDC Program requires **you** to provide VA with all evidence to support your claim at the beginning of the claim process. Evidence includes all personnel and medical records, including any private treatment records. VA will process your claim **after** your release from active duty, but processing is typically faster than for the Standard Claim Process (described below).

- **Integrated Disability Evaluation System (IDES)** is a dual DoD and VA disability evaluation process. The process is only available if you are referred by a military provider as part of a Physical Evaluation Board.

- **Benefits Delivery at Discharge (BDD) Program** is a VA claim process you may initiate while still on active duty. It is meant to help you complete the claims process sooner. To qualify for the BDD Program, you may file your claim **only** between 90-180 days **prior** to your release from active duty. If you have **less than** 90 days left on active duty, you can still file a disability claim with VA, but it will be evaluated under the Fully Developed Claim (FDC) or Standard Claim Process **after** your release from active duty.

- **Standard Claim Process** is a VA claim process you can utilize if you have **less than** 90 days until your release from active duty. With this process, VA helps you gather evidence (supporting documents such as private medical records) for your claim. Because of the time needed for VA to help you obtain evidence, the total processing time may be longer than for a FDC claim, where you collected that evidence before filing. Your Standard Claim will be processed **after** your release from active duty.

- Please check "not sure" if you have filed a claim, but you are unsure of which claim type.

Q6. Prior Disability Claims: Check "yes" if you have filed a disability claim with VA in the past. This question applies ONLY to past claims where service connection was granted or denied.

Q7. Prior Physical Examination: Check "yes" if you have had a comprehensive physical examination within the 12-month period prior to your release from active duty. Provide the date and type of examination, and check "yes" if you would like the examination to be reviewed for possible satisfaction of SHA requirements. Examination types that may qualify include a prior SHA, an Entry Level Physical, a Flight Physical, or a Special Duty Physical. Your Examining Clinician will determine if your prior examination satisfies SHA requirements. If it does not, you will be asked to schedule an appointment for the physical examination portion of the SHA.

Section II. Report of Medical History

Please complete all information in the medical history questionnaire as completely as possible. This information will be given to the Examining Clinician to review ahead of your appointment to allow adequate time for appraisal of your health history and concerns.

This is a screening questionnaire of your current health status and wellness. It gives you an opportunity to comment on any occupational exposures, injuries, illnesses, or health concerns you may have. For each response, please describe the history to the best of your ability, including dates of occurrence and treatment, as applicable.

If you are submitting a VA disability compensation claim, then VA will complete an appropriate evaluation, to include exams and completion of any necessary DBQs, to ensure that the information obtained is sufficient for rating purposes.

NOTE: "Qualifying military service" includes active duty; on orders 30 days or more in support of contingency operation(s); or on continuous active duty orders for 180 days or more. This includes active duty, any period of active duty for training, and any period of inactive duty.

A.II.1 General Medical Review

Q1. Current Medications and Supplements: List all current prescription and over-the-counter medications and supplements, including those you may take for body building, workouts, energy, weight loss, vitamins, etc.

Q2. Most Recent Military Medical Assessment / Physical Examination: Enter the date, or the closest date you recall, of your most recent military medical assessment with a physical examination. If you feel your health is significantly better or worse than at the time of that examination, provide an explanation.

Q4. Illness or Injury in the PAST MONTH: If "yes," please specify the illness or injury and what activity is affected. If more than one exists, specify each illness or injury and the activity affected.

Q5. Hearing Aids, Special Medical Supplies, Equipment, Assistive Technology Devices, Special Accommodations: Include all medically recommended/prescribed items, such as a hearing aid, a walker, a wrist brace for carpal tunnel, etc. Please indicate who recommended the item, when you wear or use it, and whether it is for your right or left side (if applicable).

Q9. Physical or Mental Health Injury or Illness on Active Duty without Seeking Medical Care: Explain the injury or illness, where it occurred (geographic location), approximately when (date), why you did not seek or receive medical care, and if you have any ongoing problems.

Q10 – Q57. Other General Medical Items: For each "yes" response, please state whether you received care for the condition, if you have any ongoing problems, and if you are currently seeing anyone for the condition (specify if primary care or specialist).

A.II.2 Joint, Spine, & Musculo-Skeletal System

For each "yes" response, please state whether you received care for the condition, if you have any ongoing problems, and if you are currently seeing anyone for the condition (specify if primary care or specialist).

A.II.3 Health & Wellness

Answer all questions to the best of your ability.

A.II.4 Hearing

Answer all questions to the best of your ability.

A.II.5 Vision

For each "yes" response, please state whether you received care for the condition, if you have any ongoing problems, and if you are currently seeing anyone for the condition. Please specify the type of provider; for example, a **primary care provider**; an **ophthalmologist** (a medical doctor or doctor of osteopathy who provides comprehensive eye care, including medical and surgical eye care); or an **optometrist** (a doctor of optometry who provides routine vision care and eye care services, but not surgical care).

Q3. Corrective Surgery: If you have had surgery to correct your vision, indicate the type of procedure, date, and hospital/clinic where the procedure was performed.

A.II.6 Head Injury

Q1. Jolt or Blow to Head: Check "yes" if you ever received a jolt or blow to your head that IMMEDIATELY caused one or more of the results listed. Place a check next to each result that occurred.

Q2. Total Times: On how many occasions did a jolt or blow to your head cause an immediate result such as losing consciousness, losing memory, or seeing stars? Give a numerical (1, 2, 3, etc.) response.

Q3. Head Injury, Concussion or TBI: If "yes," please indicate if you were formally diagnosed with a concussion or traumatic brain injury (TBI). Include the date and location/facility of diagnosis, to the best of your ability as applicable. Please include specific details regarding the injury. Include the geographic location where the injury occurred, date of injury, and if you have ever been evaluated or treated for the injury (such as at a field hospital if it occurred during a deployment, or by a provider if due to an accident).

Q4. Prolonged Symptoms:

- As a result of an injury or event where you received a jolt or blow to your head, or were diagnosed with a TBI, do you have prolonged symptoms that have not resolved? If so, check "yes" and explain what those symptoms are and how often you experience them. For example, are the symptoms chronic (they are always present) or periodic (they come and go)?

- Please indicate if you are **currently experiencing** prolonged symptoms. If "yes," indicate specifically what those symptoms are.

A.II.7 Environmental/Occupational

This section covers various potentially hazardous or unusual occupational and environmental exposures during qualifying military service. Exposures may have occurred while deployed, in training, or during other assignments.

You are asked to consider your potential exposure to burn pits, oil well fires, burning trash, dust storms, air pollution, explosions, fuels/fumes, pesticides/insecticides, cleaning agents, solvents, heavy metals/depleted uranium, nerve agents/gases, protective medication and vaccines (Pyridostigmine Bromide [PB], Lariam [Mefloquine] pills), persistent chemicals such as polychlorinated biphenyls [PCBs], asbestos, radiation, unusual food/drinking water exposures, contaminated water, and personal hygiene exposures (swimming, showering, etc.).

This form provides information to assist you in understanding your eligibility for enrollment in the VA Airborne Hazards and Open Burn Pit Registry (AHOBPR), which is separate from compensation and benefits evaluations. The AHOBPR is open to all Service members and Veterans who deployed to contingency operations in the Southwest Asia theater of operations at any time on or after August 2, 1990; or to Afghanistan or Djibouti on or after September 11, 2001. These regions include the following countries and bodies of water, and the airspace above these locations: Iraq, Afghanistan, Kuwait, Saudi Arabia, Bahrain, Djibouti, Gulf of Aden, Gulf of Oman, Oman, Qatar, and the United Arab Emirates; and waters of the Persian Gulf, Arabian Sea, Red Sea, Uzbekistan, and Syria. VA will use deployment data provided by DoD to determine eligibility. You may join the AHOBPR even if:

- You don't think, or are unsure if, you were exposed to specific airborne hazards.
- You are not experiencing symptoms or illnesses you think are related to your exposures.
- You have not filed a VA claim for compensation and benefits or applied for VA health care.
- You are still an active duty Service member, reservist, or have returned to active service.

Visit www.publichealth.VA.gov/airbornehazards to learn more about airborne hazards and the registry.

Service members who are not eligible for the registry but are concerned about their exposures can still apply for VA health care and file a claim for compensation and benefits.

A.II.8 Dental

For each "yes" response, please state whether you received care for any condition, if you have any ongoing problems, and if you are currently receiving treatment for the condition (specify type of provider).

A.II.9 Women's Health/Female Reproductive Organs

You may skip this section if it is not applicable. Please check "not applicable" at the top of the section.

Q2. Details of Disorders: For each disorder identified in Q1, please indicate if you are still undergoing active treatment. Include the date of diagnosis, treatment, medications, and treatment center.

Q4. Details of Surgeries and Injuries: For each surgery and injury identified in Q3, please indicate if you are still undergoing active treatment. Include the date of diagnosis, treatment center, and treating provider(s) as applicable.

Q5. Pregnancy: Use a separate date line for each pregnancy. More than one outcome/condition box may be selected for each date as applicable (for example, you may have had a vaginal delivery with a complication of post-partum depression, so you would select both boxes). Please provide any additional information (such as an explanation of "Other") in the space provided.

Q7. Mammogram with Abnormal Result: For any abnormal findings, please indicate if you are still under surveillance or need any further follow up testing or care.

Q9. Cervical Cancer Screening with Abnormal Result: For any abnormal findings, please indicate if you are still under surveillance or need any further follow up testing or care.

A.II.10 Mental Health Screening Questionnaires

Please complete all information in the mental health screening questionnaires. Responses will be reviewed by the Examining Clinician and additional questions may be asked.

Answer all questions to the best of your ability.

NOTE: If you are struggling with any mental health concerns and would like to speak to someone confidentially, please call the Veterans Crisis Line at 988 and press '1' or text 838255.

You have reached the end of the Self-Assessment. Please review your responses for accuracy and completeness. Correct any answers as needed. Once you are finished, sign and date this form then submit as directed.

VA | U.S. Department of Veterans Affairs

SEPARATION HEALTH ASSESSMENT

PRIVACY ACT STATEMENT

This statement serves to inform you, as required by the Privacy Act of 1974, as amended, of the purpose for collecting personal information and how that information will be stored and used.

Authority:
Title 10, United States Code (U.S.C.) § 1145, Health Benefits; Department of Defense (DoD) Instruction 6040.46, "Separation History and Physical Examination for DoD Separation Health Assessment Program"; 5 U.S.C. § 301, Departmental Regulations; 10 U.S.C. § 136, Under Secretary of Defense for Personnel and Readiness; Public Law 104-191, Health Insurance Portability and Accountability Act (HIPAA) of 1996; 10 U.S.C., Chapter 55, Medical and Dental Care; DoD Manual 6025.18, "Implementation of the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule in DoD Health Care Programs"; DoD Instruction 6490.08, "Command Notification Requirements to Dispel Stigmas in Providing Mental Health Care to Service Members"; and Executive Order 9397 (relating to Federal agency use of Social Security Numbers), as amended.

Purpose:
The information collected is used to assist the DoD and/or Department of Veterans Affairs (VA) clinical examiners in assessing the health and wellness status of individuals separating from active duty, and in determining disqualifying medical condition(s) for medical retention and/or compensation.

Routine Uses: These records may specifically be disclosed outside the DoD as a routine use pursuant to 5 U.S.C. § 552a(b)(3) as follows: to contractors and others performing or working for the Federal Government when necessary to accomplish an agency function related to this System of Records; to the Department of Health and Human Services, other Federal agencies, and academic institutions for the purposes of public health activities and conducting research; and to the VA for the purpose of providing medical care, to determine the eligibility for benefits, to coordinate cost sharing activities, and to facilitate collaborative research activities between DoD and VA. For a complete listing of the Routine Uses for this system, refer to the applicable System of Record Notice (SORN) hyperlinked below.

Any protected health information (PHI) in your records may be used and disclosed generally as permitted by the HIPAA Rules, as implemented within DoD pursuant to DoD Manual 6025.18. The use and disclosure of PHI concerning mental health care services are further limited by exigent circumstance rules and minimum necessary standards stated in DoDI 6490.08. Permitted uses and disclosures of PHI include, but are not limited to, treatment, payment, and healthcare operations.

Applicable SORN:
DoD SORN: EDHA 07, Military Health Information System (June 15, 2020, 85 FR 36190), https://www.govinfo.gov/content/pkg/FR-2020-06-15/pdf/2020-12839.pdf; VA SORNs: 58VA21/22/28, Compensation, Pension, Education, and Vocational Rehabilitation and Employment Records— VA (Nov. 8, 2021, 86 FR 61858), https://www.govinfo.gov/content/pkg/FR-2021-11-08/pdf/2021-24372.pdf; and 79VA10P2, Veterans Health Information Systems and Technology Architecture (VistA) Records-VA (Dec. 23, 2020, 85 FR 84114), https://www.govinfo.gov/content/pkg/FR-2020-12-23/pdf/2020-28340.pdf.

Disclosure: Voluntary. If you choose not to provide the requested information, there may be an administrative delay; however, no penalty may be imposed. Information provided is deemed an official statement and may be subject to the Uniform Code of Military Justice.

PART A - SERVICE MEMBER IDENTIFICATION AND SELF-ASSESSMENT

SECTION 1 - IDENTIFICATION

NOTE TO THE SERVICE MEMBER: Please complete the following subsections.

IDENTIFIER

1. Name _____

2. SSN (Social Security Number) _____

3. DoD ID Number _____

4. Today's Date (self-assessment date) (YYYYMMDD) _____

1. CONTACT INFORMATION

1. Current Address _____

2. Work Telephone Number _____

3. Personal Telephone Number _____

4. Government Email _____

5. Personal Email _____

6. Preferred method(s) of contact ◯ Mail ◯ Work Phone ◯ Personal Phone ◯ Government Email ◯ Personal Email

2. PERSONAL INFORMATION

1. Date of Birth (DoB) (YYYYMMDD) _____

2. Age _____

3. Race and Ethnicity (mark all that apply)

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American ☐ Hispanic or Latino ☐ Middle Eastern or North African

☐ Native Hawaiian or Other Pacific Islander ☐ White ☐ Other ☐ Choose not to answer

4. Birth Sex (biological sex) ◯ Female ◯ Male

3. OCCUPATIONAL INFORMATION

1. Service ◯ Army ◯ Navy ◯ Marine Corps ◯ Air Force ◯ Space Force ◯ Coast Guard
◯ Other Specify: _____

2. Component ◯ Active Duty ◯ Reserve ◯ National Guard

3. Duty Status ◯ Active Component ◯ Active Duty – Active Guard Reserve ◯ Active Duty – Non-Active Guard Reserve
◯ Not on active duty

4. Usual Occupation (most recent day-to-day job)

5. What is your military occupational code (for example: MOS, AOC, AFSC, NEC, or Designator Code)? _____

4. EXAMINATION INFORMATION

1. Exam Date (if known) (YYYYMMDD) _____

2. Purpose of Exam ◯ Separation from period of active service ◯ Retirement ◯ Separation from military service
◯ Medical Board ◯ Other Specify: _____

3. Provide date or anticipated date of release from Active Duty (YYYYMMDD) _____

4. Do you intend to file a claim, or have you already filed a claim, for disability compensation with the Veterans Benefits Administration?
◯ Yes ◯ No (if no, skip to question 6)

5. Select the type of claim program/process
◯ FDC (Fully Developed Claim) Program ◯ Standard Claim Process
◯ IDES (Integrated Disability Evaluation System) (select this option only if you have been referred to IDES by your Military Service) ◯ Not sure
◯ BDD (Benefits Delivery at Discharge) (select this option only if you meet the criteria for the BDD program)

6. Have you ever filed a disability claim with the VA?
◯ Yes ◯ No

7. Have you had a physical exam within 12 months before your separation date?
◯ Yes ◯ No ◯ Unsure (if no or unsure, skip to Section 2)

Date of exam _____ Type of exam (for example: School, Flight, Special Duty) _____

Would you like that exam reviewed to determine if it is sufficient to meet the separation health assessment requirements?
◯ Yes ◯ No

SECTION 2 - REPORT OF MEDICAL HISTORY

Please complete all information in the following medical history questionnaire before your appointment for a Separation Health Assessment (SHA) Clinical Assessment. Your responses will help us understand your current health status and wellness. For each response, briefly describe the history, including dates, as indicated and applicable. If you are submitting a VA claim, then an appropriate evaluation, to include examinations and completion of any necessary Disability Benefits Questionnaires (DBQs), will be completed at a later date in order to ensure that the available information is sufficient for rating purposes.

Note: “Qualifying military service” includes: active duty; on orders 30 days or more in support of contingency operation(s); on continuous active duty orders for 180 days or more. This includes active duty, any period of active duty for training, and any period of inactive duty. (If additional space is needed to answer a question in this section, continue your response on page 17.)

1. GENERAL MEDICAL REVIEW

1. List your current medications, including supplements.

2. Date of your most recent military service medical assessment/physical exam (YYYYMMDD) _____

Compared to your last military service medical assessment/physical exam, your overall health is:

◯ The same ◯ Better ◯ Worse

If better or worse, explain:

3. Overall, how would you rate your health during the PAST MONTH?

◯ The same ◯ Better ◯ Worse

If better or worse, explain:

4. During the PAST MONTH, did you have physical health problems (illness or injury) that made it difficult for you to do your work or other regular daily activities?

◯ Yes ◯ No If yes, explain:

5. Do you currently require hearing aids, special medical supplies, Continuous Positive Airway Pressure (CPAP), adaptive equipment, assistive technology devices, and/or other special accommodations?

◯ Yes ◯ No If yes, explain:

6. Have you had any surgery since your last health assessment/exam? (Include privately paid elective surgeries.)

◯ Yes ◯ No If yes, explain:

7. Since your last health assessment/exam, has a health care provider recommended surgery(s) that you have not had (whether you are planning to have it or not)?

◯ Yes ◯ No If yes, explain:

8. Since your last health assessment/exam, have you received care or treatment for any medical and/or mental health condition(s) from a CIVILIAN or NON-MILITARY facility? This includes privately paid treatments and/or procedures (for example: photorefractive keratectomy (PRK), wisdom teeth removal, vasectomy, botox).

◯ Yes ◯ No If yes, explain:

9. Have you suffered from any injury or illness while on active duty for which you did not seek medical care (to include mental health)?

◯ Yes ◯ No If yes, explain:

During qualifying military service, have you ever experienced:

10. Allergies, including environmental and occupational allergies, and adverse reaction to serum, food, insect stings, or medicine.

◯ Yes ◯ No If yes, explain:

11. High or bad cholesterol

◯ Yes ◯ No If yes, explain:

12. Tuberculosis

◯ Yes ◯ No If yes, explain:

13. Coughing up blood

◯ Yes ◯ No If yes, explain:

14. Asthma

◯ Yes ◯ No If yes, explain:

15. Bronchitis

◯ Yes ◯ No If yes, explain:

16. Chronic cough or cough at night

◯ Yes ◯ No If yes, explain:

17. Wheezing, shortness of breath, or difficulty breathing (other than asthma)

◯ Yes ◯ No If yes, explain:

18. Other lung problems (for example: Chronic Obstructive Pulmonary Disease (COPD), chronic bronchitis, pneumonia, emphysema)

◯ Yes ◯ No If yes, explain:

19. Sinusitis

◯ Yes ◯ No If yes, explain:

20. Thyroid trouble or goiter

◯ Yes ◯ No If yes, explain:

21. Ear, nose, or throat trouble

◯ Yes ◯ No If yes, explain:

22. Frequent indigestion or heartburn (reflux)

◯ Yes ◯ No If yes, explain:

23. Stomach or intestinal problems (for example: ulcer)

◯ Yes ◯ No If yes, explain:

24. Kidney problems (for example: stones, infection

◯ Yes ◯ No If yes, explain:

25. Liver problems (for example: hepatitis, cirrhosis)

◯ Yes ◯ No If yes, explain:

26. Constipation, loose bowels, or diarrhea

◯ Yes ◯ No If yes, explain:

27. Gallbladder trouble or gallstones

◯ Yes ◯ No If yes, explain:

28. Hernia

◯ Yes ◯ No If yes, explain:

29. Rectal disease, hemorrhoids, or blood from rectum

◯ Yes ◯ No If yes, explain:

30. Frequent or painful urination or blood in urine

◯ Yes ◯ No If yes, explain:

31. High or low blood sugar

◯ Yes ◯ No If yes, explain:

32. Sugar or protein in urine

◯ Yes ◯ No If yes, explain:

33. Diabetes

◯ Yes ◯ No If yes, explain:

34. Recent unexplained gain or loss of weight

◯ Yes ◯ No If yes, explain:

35. A head injury, memory loss, or amnesia

◯ Yes ◯ No If yes, explain:

36. Recurring headaches/ migraines; frequent or severe headaches

◯ Yes ◯ No If yes, explain:

37. Periods of dizziness, fainting, or loss of consciousness

◯ Yes ◯ No If yes, explain:

38. Mental health problems (for example: depression, anxiety, Post-Traumatic Stress Disorder (PTSD), worry, or other mental health diagnosis)

◯ Yes ◯ No If yes, explain:

39. Neurological problems (for example: stroke, seizures, convulsions, epilepsy, fits, tremor)

◯ Yes ◯ No If yes, explain:

40. Paralysis

◯ Yes ◯ No If yes, explain:

41. Meningitis, encephalitis, or other neurological infection or disorder

◯ Yes ◯ No If yes, explain:

42. Rheumatic fever

◯ Yes ◯ No If yes, explain:

43. Prolonged bleeding

◯ Yes ◯ No If yes, explain:

44. Blood problems (for example: hemophilia, sickle cell disease)

◯ Yes ◯ No If yes, explain:

45. Immune system problems (for example: HIV, chemotherapy, radiation)

◯ Yes ◯ No If yes, explain:

46. Angina, also called angina pectoris

◯ Yes ◯ No If yes, explain:

47. Congestive Heart Failure

◯ Yes ◯ No If yes, explain:

48. Pain, pressure, or discomfort in your chest

◯ Yes ◯ No If yes, explain:

49. Palpitations, pounding heart, or abnormal heartbeat

◯ Yes ◯ No If yes, explain:

50. Heart murmur or valve problem (for example: mitral valve prolapse)

◯ Yes ◯ No If yes, explain:

51. Coronary heart disease

◯ Yes ◯ No If yes, explain:

52. Heart attack (also called myocardial infarction)

◯ Yes ◯ No If yes, explain:

53. High blood pressure

◯ Yes ◯ No If yes, explain:

54. Low blood pressure

◯ Yes ◯ No If yes, explain:

55. Skin diseases (other than cancer)

◯ Yes ◯ No If yes, explain:

56. Cancer (other than skin)

◯ Yes ◯ No If yes, explain:

57. Skin cancer

◯ Yes ◯ No If yes, explain:

2. JOINT, SPINE, & MUSCULOSKELETAL SYSTEM

During qualifying military service, have you ever experienced pain and/or injury in the following:

1. Head and Neck

◯ Yes ◯ No If yes, explain:

2. Back and Chest

◯ Yes ◯ No If yes, explain:

3. Shoulder/Arm

◯ Yes ◯ No If yes, explain:

4. Elbow/Forearm

◯ Yes ◯ No If yes, explain:

5. Wrist/Hand/Fingers

◯ Yes ◯ No If yes, explain:

6. Hip/Thigh

◯ Yes ◯ No If yes, explain:

7. Leg/Knee

◯ Yes ◯ No If yes, explain:

8. Ankle/Foot/Toes

◯ Yes ◯ No If yes, explain:

3. HEALTH & WELLNESS

1. Do you currently use tobacco products (cigarettes, cigars, pipes, etc.), electronic nicotine products (e-cigarette/JUUL, e-hookah, vape-pen, vaporizer, tank system, other similar nicotine products), smokeless tobacco products (chewing tobacco, snuff, dip, snus (pronounced as “snoose”), or dissolvable tobacco)?

◯ Yes ◯ No If yes, explain:

2. Have you smoked at least 100 cigarettes in your entire life? (Note: A pack typically contains 20 cigarettes)

◯ Yes ◯ No If no, skip to question 5.

3. During the past 12 months, have you ever tried to stop smoking?

◯ Yes ◯ No ◯ Not Applicable If yes, explain:

4. Have you ever had a serious health problem that was caused or made worse by smoking?

◯ Yes ◯ No If yes, explain:

5. During the past 12 months, how often were you exposed to secondhand smoke indoors (home, work, vehicle, etc.), a mixture of smoke that comes from the burning end of a tobacco product (cigarettes, cigars, pipes, etc.), or vapor indoors from a person using an e-cigarette/JUUL, ehookah, vape-pen, vaporizer, tank system, or other similar nicotine product?

◯ Daily ◯ Less than daily ◯ Not at all

6. Do you have any ongoing health concerns with past use of recreational drugs or misuse of prescription drugs?

◯ Yes ◯ No If yes, explain:

4. HEARING

1. During qualifying military service have you ever had, or do you now have, persistent or recurring noises in your head or ears? (for example: ringing, buzzing, humming)

◯ Yes ◯ No If yes, explain:

2. During qualifying military service have you ever had, or do you now have, a change in your hearing that impacts duty performance?

◯ Yes ◯ No If yes, explain:

3. Do you currently, or have you ever worn, a hearing aid?

◯ Yes ◯ No If yes, explain:

4. During your deployment or during military training, were you exposed to loud noises, to include blasts, that resulted in a temporary or permanent decrease in hearing and/or ringing, humming, buzzing sounds in your ears or head? If yes, how many times? For how long? Describe exposure and any symptoms you are still experiencing.

◯ Yes ◯ No If yes, explain:

5. VISION

1. Do you wear corrective lenses (glasses or contacts)?

◯ Yes ◯ No If yes, explain:

During qualifying military service, have you ever experienced:

2. Eye disorder or trouble

◯ Yes ◯ No If yes, explain:

3. Surgery to correct vision

◯ Yes ◯ No If yes, explain:

4. Loss of vision in either eye

◯ Yes ◯ No If yes, explain:

5. Double vision (diplopia)

◯ Yes ◯ No If yes, explain:

6. Change in your vision that impacts your duty performance

◯ Yes ◯ No If yes, explain:

6. HEAD INJURY

During qualifying military service:

1. As a result of any injury or event, did you receive a jolt or blow to your head that IMMEDIATELY resulted in losing consciousness; losing memory of events before or after the injury; or seeing stars, becoming disoriented, functioning differently, or nearly blacking out?

◯ Yes ◯ No ◯ Not Applicable

If yes, check all that apply:

☐ Losing consciousness ("knocked out")?

☐ Losing memory of events before or after the injury?

☐ Seeing stars, becoming disoriented, functioning differently, or nearly blacking out?

2. How many total times did you receive a jolt or blow to your head? _____

3. Have you ever experienced a head injury, concussion, or Traumatic Brain Injury (TBI)?

◯ Yes ◯ No If yes, explain:

4. As a result of any injury or event, where you received a jolt or blow to your head, or were diagnosed with a TBI:

Have you had prolonged symptoms that have not resolved?

◯ Yes ◯ No If yes, explain:

Are you currently experiencing any prolonged symptoms that have not resolved?

◯ Yes ◯ No If yes, explain:

7. ENVIRONMENTAL/OCCUPATIONAL

This section covers various potentially hazardous occupational and environmental exposures during qualifying military service. Exposures may have occurred while deployed, in training, or during other assignments. Consider your potential exposure to: burn pits, oil well fires, burning trash, dust storms, air pollution, explosions, fuels/fumes, pesticides/insecticides, cleaning agents, solvents, heavy metals/depleted uranium, nerve agents/gases, protective medication and vaccines (for example: Pyridostigmine Bromide (PB), Lariam (Mefloquine) pills), persistent chemicals such as PCBs, asbestos, radiation, unusual food/drinking water exposures, contaminated water, and personal hygiene exposures (for example: swimming, showering, etc.).

1. Were you potentially exposed to any occupational/environmental hazards (described above) while in a qualifying military duty service?

◯ Yes ◯ No ◯ Unsure If yes or unsure, provide details here:

2. Have you been based or stationed at a location where an open burn pit was used?

◯ Yes ◯ No ◯ Unsure If yes or unsure, provide details here:

3. Have you been potentially exposed to toxic airborne chemicals or other airborne contaminants?

◯ Yes ◯ No ◯ Unsure If yes or unsure, provide details here:

4. If 2 or 3 is “Yes” or “Unsure,” have you enrolled in the Airborne Hazards and Open Burn Pit Registry?

◯ Yes ◯ No ◯ Not Applicable

5. Federal law requires eligible members to enroll in the Airborne Hazards and Open Burn Pit Registry or to opt-out. If eligible choose one:

See page 13 for more information on the registry.

I wish to: ◯ enroll ◯ opt out ◯ Not Applicable

6. While deployed, were you potentially exposed to other deployment-related hazards?

◯ Yes ◯ No ◯ Unsure If yes or unsure, provide details here:

7. During any part of your qualifying military service, were you exposed to any of the following? (check all that apply)

- ☐ Medications to prevent malaria/malaria prophylaxis, including Mefloquine
- ☐ A vaccine with a possible complication
- ☐ Firefighting foam
- ☐ Solvents or other chemicals that may have caused skin reactions, breathing problems, or other concerns
- ☐ Fuels
- ☐ Contaminated water
- ☐ Radiation (include any possible exposure to depleted uranium)
- ☐ Other exposures of possible concern not listed here
- ☐ Embedded shrapnel
- ☐ Unsure

8. If you checked any exposures, including “unsure,” listed in question 7, please explain your exposure concerns, being as specific as possible.

Provide details of exposure concerns here:

9. Are you currently participating in any specialty occupational exposure examinations?

◯ Yes ◯ No If yes, explain:

During qualifying military service, have you ever experienced:

10. A blast or explosion?

◯ Yes ◯ No If yes, explain:

11. A vehicular accident/crash (any vehicle including aircraft)?

◯ Yes ◯ No If yes, explain:

12. A fragment wound or bullet wound?

◯ Yes ◯ No If yes, explain:

The Airborne Hazards and Open Burn Pit Registry (AHOBPR)

Are you eligible to participate? AHOBPR is open to Service members and Veterans who deployed to contingency operations in the Southwest Asia theater of operations at any time on or after August 2, 1990, or Afghanistan or Djibouti on or after September 11, 2001. The Southwest Asia theater includes the following countries, bodies of water, and the airspace above these locations: Iraq, Kuwait, Saudi Arabia, Bahrain, Gulf of Aden, Gulf of Oman, Oman, Qatar, and the United Arab Emirates; and waters of the Persian Gulf, Arabian Sea, Red Sea, Uzbekistan, and Syria. The VA will use deployment data provided by DoD to determine your eligibility. You can join the AHOBPR even if:

- You do not think you were exposed to specific airborne hazards.
- You are not experiencing symptoms or illnesses you think are related to exposures.
- You have not filed a VA claim for compensation and benefits or applied for VA health care.
- You are still an active duty Service member, reservist, or have returned to active service.

Visit www.publichealth.VA.gov/airbornehazards to learn more about airborne hazards and the AHOBPR.

If you are not eligible for the AHOBPR but are concerned about your exposures, you can still apply for VA health care and file a claim for compensation and benefits

8. DENTAL

1. Do you currently have any dental problems that need to be evaluated?

◯ Yes ◯ No If yes, explain:

2. Have you ever been diagnosed or treated for oral cancer?

◯ Yes ◯ No If yes, explain:

During qualifying military service, have you ever experienced:

3. A dental examination where you were told you had a Temporomandibular Disorder (TMD) or Temporomandibular Joint (TMJ) problem?

◯ Yes ◯ No If yes, explain:

4. Your jaw locked open and you could not close the jaw?

◯ Yes ◯ No If yes, explain:

5. Loss of a portion of the bone in your upper or lower jaw due to trauma or disease such as osteomyelitis or necrosis?

◯ Yes ◯ No If yes, explain:

6. Loss of any teeth because of service-related trauma?

◯ Yes ◯ No If yes, explain:

7. Physical (anatomical) loss or injury to your mouth, lips, or tongue?

◯ Yes ◯ No If yes, explain:

9. WOMEN'S HEALTH / FEMALE REPRODUCTIVE ORGANS ☐ Not Applicable

During qualifying military service, have you ever:

1. Been diagnosed with and/or treated for any of the following disorders? (check all that apply)

☐ Endometriosis

Date (YYYYMMDD): _____

Diagnosed by laparoscopy?

◯ Yes

◯ No

◯ Unsure

☐ Fibroids (leiomyomas)

☐ Rectocele or cystocele

☐ Polycystic Ovarian Syndrome (PCOS)

☐ Infertility/difficulty getting pregnant

☐ Recurrent miscarriage (2 or more pregnancy losses)

☐ Ovarian cancer

☐ Cervical cancer

☐ Uterine/endometrial cancer

☐ Breast cancer

☐ Bone loss or osteoporosis

☐ Frequent urinary tract infections

☐ Urinary or fecal incontinence (leaking urine or stool)

2. Please provide additional details for all marked disorders in question 1 (for example: date diagnosed, treatment, medications, and treatment center).

3. Had any of the following surgeries or injuries? (check all that apply)

☐ Breast surgery or breast biopsy

☐ Hysterectomy (uterus removed)

☐ Oophorectomy (ovaries removed)

◯ One ovary

◯ Both ovaries

☐ Other uterine surgery (C-section, dilation and curettage (D&C), endometrial ablation, removal of fibroids, or other uterine surgery)

☐ Other ovarian surgery

☐ Removal of ovarian cyst

☐ Treatment of ovarian torsion (twisting)

☐ Tubal surgery including tubal ligation

☐ Surgery for urinary/ fecal incontinence (leaking urine/stool)

☐ LEEP or cervical cone biopsy

☐ Vaginal/vulvar surgery or injury

4. Please provide additional detail for all marked surgeries in question 3 (for example: date diagnosed, treatment center).

5. Pregnancy. List all pregnancies and associated outcomes and conditions.

Date (YYYYMMDD)	Vaginal Delivery	C-Section	Miscarriage (loss before 20 weeks)	Stillbirth (loss at or after 20 weeks)	Ectopic (Tubal)	Termination (Abortion)	Complications* (Depression or Anxiety)	Other**
_____	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐
_____	☐	☐	☐	☐	☐	☐	☐	☐

List dates, outcomes, treatment location, and complications, if any.
*Complications include, but are not limited to: depression, anxiety, high blood pressure in pregnancy, preeclampsia, etc.
**Provide additional information, as necessary (for example: gestational diabetes).

Have you ever had:

6. A breast cancer screening (mammogram)?

◯ Yes ◯ No ◯ Unsure (if no or unsure, skip to question 8)

If yes, when was your last screening? (YYYYMM) _____

7. An abnormal mammogram result?

◯ Yes ◯ No ◯ Unsure (if no or unsure, skip to question 8)

If yes, when did the abnormal result occur? What was the abnormal result? (YYYYMM)/Result

If applicable, when did you receive treatment or follow-up care? What was the treatment or follow-up care? (YYYYMM)/Treatment or Follow-up Care

8. A cervical cancer screening (Pap and/or HPV test):

◯ Yes ◯ No ◯ Unsure (if no or unsure, skip to question 10)

If yes, when was your last screening? (YYYYMM) _____

9. An abnormal result showing cancer or pre-cancer or a positive HPV test?

◯ Yes ◯ No ◯ Unsure (if no or unsure, skip to question 10)

If yes, when did the abnormal result occur? What was the abnormal result? (YYYYMM)/Result

If applicable, when did you receive treatment or follow-up care? What was the treatment or follow-up care? (YYYYMM)/Treatment or Follow-up Care

Are you currently:

10. Still having menses (periods)?

◯ Yes ◯ No ◯ Unsure

If yes, enter the date of your last menstrual period and skip to question 11. (YYYYMMDD) _____

If no or unsure, why are you not having menses (periods)?

- ☐ Postmenopausal (no periods for 12 months or more)
- ☐ Hysterectomy
- ☐ Hormonal suppression (pills/ring/patch/shot/ IUD)
- ☐ Pregnant
- ☐ Lactating (breastfeeding)
- ☐ Unsure
- ☐ Other Specify _____

If you remember, what was the date of your last menstrual period? (YYYYMM) _____

11. Experiencing any of the following? (check all that apply)

- ☐ Current or recent genital lesions (sores on or near your vaginal area)
- ☐ Pain during intercourse
- ☐ Pelvic pain
- ☐ Pelvic inflammatory disease, uterus prolapse, or displacement
- ☐ Low libido (reduced interest in sex)
- ☐ Leakage of stool
- ☐ Leakage of urine affecting work/ social activities
- ☐ Bleeding after menopause
- ☐ No

If yes, explain:

10. MENTAL HEALTH SCREENING QUESTIONNAIRES

NOTE TO THE SERVICE MEMBER: Please respond to the following screening questionnaires. Your responses will be reviewed by the Examining Clinician, and additional questions may be asked.

10.1 DEPRESSION SCREEN

Over the last 2 weeks, how often have you been bothered by any of the following problems?

1. Little interest or pleasure in doing things?

◯ Not At All ◯ Several Days ◯ More Than Half the Days ◯ Nearly Every Day

2. Feeling down, depressed, or hopeless?

◯ Not At All ◯ Several Days ◯ More Than Half the Days ◯ Nearly Every Day

10.2 ALCOHOL USE SCREEN

1. How often did you have a drink containing alcohol in the past year?

◯ Never (Proceed to signature) ◯ Monthly or less ◯ 2-4 times a month

◯ 2-3 times per week ◯ 4 or more times a week

2. How many drinks containing alcohol did you have on a typical day when you were drinking in the past year?

◯ 1 or 2 ◯ 3 or 4 ◯ 5 or 6 ◯ 7 to 9 ◯ 10 or more

3. For men: How often did you have six or more drinks on one occasion in the past year?

◯ Never ◯ Less than monthly ◯ Monthly

◯ Weekly ◯ Daily, or almost daily ◯ Not Applicable

4. For women: How often did you have four or more drinks on one occasion in the past year?

◯ Never ◯ Less than monthly ◯ Monthly

◯ Weekly ◯ Daily, or almost daily ◯ Not Applicable

10.3 POST-TRAUMATIC STRESS DISORDER (PTSD) SCREEN

Sometimes things happen to people that are unusually or especially frightening, horrible, or traumatic. For example:

- a serious accident or fire
- a physical or sexual assault or abuse
- an earthquake or flood
- a war
- seeing someone be killed or seriously injured
- having a loved one die through homicide or suicide.

Have you ever experienced this kind of event?

◯ Yes ◯ No

If no, screen total = 0. Please stop here.

If yes, please answer the questions below.

In the past month, have you...

1. Had nightmares about the event(s) or thought about the event(s) when you did not want to?

◯ Yes ◯ No

2. Tried hard not to think about the event(s) or went out of your way to avoid situations that reminded you of the event(s)?

◯ Yes ◯ No

3. Been constantly on guard, watchful, or easily startled?

◯ Yes ◯ No

4. Felt numb or detached from people, activities, or your surroundings?

◯ Yes ◯ No

5. Felt guilty or unable to stop blaming yourself or others for the event(s) or any problems the event(s) may have caused?

◯ Yes ◯ No

Before submitting, please review your responses to ensure they are accurate and complete.

Space for additional response(s). Note the question number before each response (for example, 3.1).

Signature of Service member

Date of signature (YYYYMMDD)

OMB Approved No. 2900-0659
Respondent Burden: 45 minutes
Expiration Date: 03/31/2027

Department of Veterans Affairs

VA DATE STAMP
(DO NOT WRITE IN THIS SPACE)

STATEMENT IN SUPPORT OF CLAIMED MENTAL HEALTH DISORDER(S) DUE TO AN IN-SERVICE TRAUMATIC EVENT(S)

INSTRUCTIONS: Before completing this form, we encourage you to read the Privacy Act and Respondent Burden on page 7. Use this form to provide a statement in support of a claimed mental health disorder(s) due to an in-service traumatic event(s). For more information, you can contact us online through Ask VA: **https://ask.va.gov/** or call us toll-free at 1-800-698-2411 (TTY:711). VA forms are available at **www.va.gov/vaforms**.

SECTION I: VETERAN/SERVICE MEMBER'S IDENTIFICATION INFORMATION

NOTE: You may complete the form online or by hand. If completed by hand, print the information requested in ink, neatly and legibly and insert one letter per box to help expedite processing of the form.

1. VETERAN/SERVICE MEMBER'S NAME (First, Middle Initial, Last)

2. SOCIAL SECURITY NUMBER	3. VA FILE NUMBER (If applicable)	4. DATE OF BIRTH (MM/DD/YYYY)

5. VETERAN'S SERVICE NUMBER (If applicable)	6. TELEPHONE NUMBER (Include Area Code) Enter International Phone Number (If applicable) _____

7. E-MAIL ADDRESS (Optional)

SECTION II: TRAUMATIC EVENT(S) INFORMATION

8. SELECT THE TYPE OF IN-SERVICE TRAUMATIC EVENT(S) YOU EXPERIENCED (Check more than one, if applicable)

- ☐ COMBAT TRAUMATIC EVENT(S)
- ☐ PERSONAL TRAUMATIC EVENT(S) (not involving military sexual trauma (MST)
- ☐ PERSONAL TRAUMATIC EVENT(S) (involving MST) (if checked review Section VI)
- ☐ OTHER TRAUMATIC EVENT(S)

IMPORTANT: It is helpful, but not required, to complete all applicable sections of the form. Please provide information about where and when the in-service traumatic event(s) occurred. Including this information will help to identify records and sources of information that may support your claim. If you are unable to include this information or only provide approximate dates or locations, VA will still review and consider all the evidence available to support your claim. **See the following three examples for guidance on how to complete Items 9A through 9C**.

EXAMPLES OF BRIEF DESCRIPTION OF THE TRAUMATIC EVENT(S)	EXAMPLES OF LOCATION OF THE TRAUMATIC EVENT(S)	EXAMPLES OF DATES THE TRAUMATIC EVENT(S) OCCURED
Example 1. Corpsman on medical ship in Da Nang harbor, Vietnam	STATIONED ON U.S.S. XYZ	SUMMER OF '70
Example 2. Mugged	BACK ALLEY IN BIG TOWN, USA	JUNE 2007
Example 3. Sexually assaulted by drill instructor	FORT XYZ	BOOT CAMP

Note: Briefly summarize the nature of the traumatic event(s) you experienced. While providing this information may be difficult, this information may help identify evidence to support your claim. If you provide name(s) of other individuals who were involved or present during the traumatic event(s), VA will not contact these individual(s). Please know providing name(s) is not required for VA to continue processing your claim. **Use Section V: "Remarks" if additional space is needed**.

	9A. BRIEF DESCRIPTION OF THE TRAUMATIC EVENT(S) (e.g., injury in warfare, physical assault, sexual harassment, witnessed the death or injury of a person, etc.)	9B. LOCATION OF THE TRAUMATIC EVENT(S) (e.g., unit assignment, residence, off-base, duty station or state, if known)	9C. DATE(S) THE TRAUMATIC EVENT(S) OCCURED (e.g., month(s) or year(s), if known, or approximate dates are acceptable)
1.			
2.			
3.			

SECTION II: TRAUMATIC EVENT(S) INFORMATION (Continued)			
4.			
5.			
6.			

SECTION III: ADDITIONAL INFORMATION ASSOCIATED WITH THE IN-SERVICE TRAUMATIC EVENT(S)

IMPORTANT: This information will help us identify records or sources of evidence that may support your claim. If you are unable to include this information, VA will still review and consider all the evidence available to support your claim. **If additional space is needed, use Section V: "Remarks"**.

Note: VA understands that in-service traumatic event(s) may not have been reported or documented. In these situations, other information, such as behavioral changes and/or sources of evidence, may be used to support the in-service traumatic event(s).

10. INDICATE ANY BEHAVIORAL CHANGES FOLLOWING THE IN-SERVICE PERSONAL TRAUMATIC EVENT(S) (**Note**: Behavioral changes can include but are not limited to the examples listed in Items 10A through 10C. If your traumatic event(s) is combat only, you may skip to Item 11.)

	A. BEHAVIORAL CHANGES EXPERIENCED FOLLOWING THE TRAUMATIC EVENT(S) (Check any box that applies)	B. ADDITIONAL INFORMATION ABOUT THE BEHAVIORAL CHANGES (If applicable) (e.g., approximate time change occurred, documentation, or record)
☐	INCREASED/DECREASED VISITS TO A HEALTHCARE PROFESSIONAL, COUNSELOR, OR TREATMENT FACILITY	
☐	REQUEST FOR A CHANGE IN OCCUPATIONAL SERIES OR DUTY ASSIGNMENT	
☐	INCREASED/DECREASED USE OF LEAVE	
☐	CHANGES IN PERFORMANCE OR PERFORMANCE EVALUATIONS	
☐	EPISODES OF DEPRESSION, PANIC ATTACKS, OR ANXIETY	
☐	INCREASED/DECREASED USE OF PRESCRIPTION MEDICATIONS	
☐	INCREASED/DECREASED USE OF OVER-THE-COUNTER MEDICATIONS	
☐	INCREASED/DECREASED USE OF ALCOHOL OR DRUGS	
☐	DISCIPLINARY OR LEGAL DIFFICULTIES	
☐	CHANGES IN EATING HABITS, SUCH AS OVEREATING OR UNDEREATING, OR SIGNIFICANT CHANGES IN WEIGHT	

SECTION III: ADDITIONAL INFORMATION ASSOCIATED WITH THE IN-SERVICE TRAUMATIC EVENT(S) (Continued)

☐	PREGNANCY TESTS AROUND THE TIME OF THE TRAUMATIC EVENT(S)	
☐	TESTS FOR SEXUALLY TRANSMITTED INFECTIONS	
☐	ECONOMIC OR SOCIAL BEHAVIORAL CHANGES	
☐	CHANGES IN OR BREAKUP OF A SIGNIFICANT RELATIONSHIP	

C. AS NEEDED, LIST ANY ADDITIONAL BEHAVIORAL CHANGES FOLLOWING THE IN-SERVICE PERSONAL TRAUMATIC EVENT(S) THAT WERE **NOT LISTED** IN ITEM 10A.

11. WAS AN OFFICIAL REPORT FILED? (**Note**: When reporting a sexual assault during military service, the Department of Defense offers two different reporting options, restricted or unrestricted. Knowing the report type will help VA take the necessary steps to obtain a copy of the report. If you are unsure which report was filed, VA may send you a follow up letter with additional information. Submitting a restricted or unrestricted report was not an option prior to 2005.)

☐ YES (If "Yes," check the appropriate box below indicating which type of report was filed)

☐ NO (If "No," skip to Item 12)

☐ RESTRICTED ☐ UNRESTRICTED ☐ NEITHER

☐ POLICE REPORT (Provide location, if known)

☐ OTHER (e.g., After Action Report (AAR), incident report, formal complaint, Judge Advocate General (JAG), Criminal Investigative Division (CID), Naval Criminal Investigative Service (NCIS), etc.)

12. POSSIBLE SOURCES OF EVIDENCE FOLLOWING THE TRAUMATIC EVENT(S) (Check all that apply) (**Note**: The following sources of evidence may provide additional information for your claim. This list is not all inclusive. If you have any individual(s)/witness(es) who know(s) about the in-service traumatic event(s) or would have knowledge of a behavioral change you experienced after the personal traumatic event(s), and wants to provide a statement on your behalf, use VA Form 21-10210, *Lay/Witness Statement*. If your individual(s)/witness(es) is a veteran, they may be requested to provide their DD Form 214, or other evidence of service.)

☐ A RAPE CRISIS CENTER OR CENTER FOR DOMESTIC ABUSE
☐ A COUNSELING FACILITY OR HEALTH CLINIC
☐ FAMILY MEMBERS OR ROOMMATES
☐ A FACULTY MEMBER
☐ CIVILIAN POLICE REPORTS
☐ MEDICAL REPORTS FROM CIVILIAN PHYSICIANS OR CAREGIVERS WHO TREATED YOU IMMEDIATELY FOLLOWING THE INCIDENT OR SOMETIME LATER
☐ A CHAPLAIN OR CLERGY
☐ FELLOW SERVICE MEMBER(S)
☐ PERSONAL DIARIES OR JOURNALS
☐ NONE
☐ OTHER (Specify below):

SECTION IV: TREATMENT INFORMATION

13A. HAVE YOU RECEIVED TREATMENT RELATED TO THE IMPACT OF THE TRAUMATIC EVENT(S) LISTED IN ITEM 9A?

☐ YES (If "Yes," complete Items 13B through 13E) ☐ NO (If "No," skip to Item 14)

13B. IDENTIFY WHERE YOU HAVE RECEIVED TREATMENT (Check all that apply)

☐ PRIVATE HEALTHCARE PROVIDER (including non-Federal records)
☐ VA VET CENTER
☐ COMMUNITY CARE (Paid for by VA)
☐ VA MEDICAL CENTER(S) (VAMC) AND COMMUNITY-BASED OUTPATIENT CLINICS (CBOC)
☐ DEPARTMENT OF DEFENSE (DOD) MILITARY TREATMENT FACILITY(IES) (MTF)

Note: VA has access to VAMC, CBOC, and MTF records. A consent form is not needed. However, if you would like VA to attempt to obtain your **private provider (excluding community care (paid for by VA)) or VA Vet Center health records**, VA requires your consent by completing VA Form 21-4142, and VA Form 21-4142a. VA forms are available at **www.va.gov/vaforms**

SECTION IV: TREATMENT INFORMATION (Continued)

Note: If VAMC, CBOC, or MTF treatment began from 2005 to present, you **do not** need to provide dates in Item 13D.

13C. NAME AND LOCATION OF THE TREATMENT FACILITY	13D. DATE(S) OF TREATMENT (Approximate dates are acceptable) (MM-YYYY)	13E. CHECK THE BOX IF YOU DO NOT HAVE DATE(S) OF TREATMENT
		☐ Don't have date
		☐ Don't have date
		☐ Don't have date

SECTION V: REMARKS

Note: This section is optional and can be left blank. However, if additional space is needed to fully answer a previous question or if needed, use this section to provide any additional information that you feel is important for us to know that may support your claim.

14. REMARKS (If any)

SECTION VI: OPTION FOR VETERANS BENEFIT ADMINISTRATION (VBA) TO NOTIFY VETRANS HEALTH ADMINISTRATION (VHA) ABOUT CERTAIN UPCOMING EVENTS DURING THE CLAIM AND/OR APPEAL PROCESS

(Note: This section only applies if you checked personal traumatic event(s) (involving MST) in Item 8)

15. If you are filing a claim for compensation for a condition due to a personal traumatic event(s) (involving MST) and you are registered and/or enrolled for VHA health care, you have the option for VBA to electronically notify VHA about certain upcoming event(s) during your claim and/or appeal process. These events are any scheduled compensation and pension (C&P) examination, hearing before the Board of Veterans' Appeals, and any decision notification. When notified, VHA will place an indicator in your medical record to alert VA health care providers that these events are scheduled to occur. Notifications to VHA would only indicate the type of event and potential time frame, not any details specific to your claim. The indicator in your medical record would not identify your claim as MST-related, but at this time, only claimants filing MST-related claims are provided this notification option. For this reason, providers may know that the indicator is in relation to an MST-related claim. The decision to **consent, not consent,** or **revoke prior consent** into the automatic notification system will not affect the status or outcome of your claim. If you would like VBA to send these electronic notifications to VHA, please indicate your consent by selecting a check box below.

☐ A. I **CONSENT** TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENTS RELATED TO MY CLAIM AND/OR APPEAL (**Note**: I understand that an indicator for these events will appear in my VHA medical record)

☐ B. I **DO NOT CONSENT** TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENTS RELATED TO MY CLAIM AND/OR APPEAL (**Note**: I understand that an indicator for these events will not appear in my VHA medical record)

☐ C. I **REVOKE PRIOR CONSENT** TO HAVE VBA NOTIFY VHA ABOUT CERTAIN UPCOMING EVENTS RELATED TO MY CLAIM AND/OR APPEAL (**Note**: I understand that in the future, notice of these events will no longer appear in my VHA medical record)

☐ D. **NOT APPLICABLE AND/OR NOT ENROLLED OR REGISTERED IN VHA HEALTHCARE**

Note: You have the option to modify your previous selection at any time. Mail your correspondence to: **Department of Veterans Affairs, Compensation Intake Center, P.O. Box 4444, Janesville, WI 53547-4444**.

SECTION VII: CERTIFICATION AND SIGNATURE

I CERTIFY THAT the foregoing statement(s) are true and correct to the best of my knowledge and belief.

16A.VETERAN/SERVICE MEMBER'S SIGNATURE	16B. DATE SIGNED (MM/DD/YYYY)

SECTION VIII: WITNESSES TO SIGNATURE
(Note: Only use this section if the veteran/service member signed Item 16A with an "X")

17A. SIGNATURE OF WITNESS	17B. PRINTED NAME AND ADDRESS OF WITNESS

18A. SIGNATURE OF WITNESS	18B. PRINTED NAME AND ADDRESS OF WITNESS

SECTION IX: ALTERNATE SIGNER CERTIFICATION AND SIGNATURE
(Note: Only required if Item 16A is blank)

NOTE: An alternate signer signature will not be accepted unless a valid VA Form 21-0972, *Alternate Signer Certification*, is of record or attached to this request.

I CERTIFY THAT by signing on behalf of the claimant, that I am a court-appointed representative; **OR**, an attorney in fact or agent authorized to act on behalf of a claimant under a durable power of attorney; **OR**, a person who is responsible for the care of the claimant, to include but not limited to a spouse or other relative; **OR**, a manager or principal officer acting on behalf of an institution which is responsible for the care of an individual; **AND**, that the claimant is under the age of 18; **OR**, is mentally incompetent to provide substantially accurate information needed to complete the form, or to certify that the statements made on the form are true and complete; **OR**, is physically unable to sign this form.

I understand that I may be asked to confirm the truthfulness of the answers to the best of my knowledge under penalty of perjury. I also understand that VA may request further documentation or evidence to verify or confirm my authorization to sign or complete an application on behalf of the claimant if necessary. Examples of evidence which VA may request include: Social Security Number (SSN) or Taxpayer Identification Number (TIN); a certificate or order from a court with competent jurisdiction showing your authority to act for the claimant with a judge's signature and a date/time stamp; copy of documentation showing appointment of fiduciary; durable power of attorney showing the name and signature of the claimant and your authority as attorney in fact or agent; health care power of attorney, affidavit or notarized statement from an institution or person responsible for the care of the claimant indicating the capacity or responsibility of care provided; or any other documentation showing such authorization.

19A. ALTERNATE SIGNER'S SIGNATURE	19B. DATE SIGNED (MM/DD/YYYY)

SECTION X: POWER OF ATTORNEY (POA) SIGNATURE
(Note: Only required if Item 16A is blank)

I CERTIFY THAT the claimant has authorized the undersigned representative to file this claim on behalf of the claimant and that the claimant is aware and accepts the information provided in this document. I certify that the claimant has authorized the undersigned representative to state that the claimant certifies the truth and completion of the information contained in this document to the best of claimant's knowledge.

Note: A POA's signature will not be accepted unless at the time of submission of this claim a valid VA Form 21-22, *Appointment of Veterans Service Organization as Claimant's Representative*, or VA Form 21-22a, *Appointment of Individual as Claimant's Representative*, indicating the appropriate POA is of record with VA.

20A. POA/AUTHORIZED REPRESENTATIVE'S SIGNATURE	20B. DATE SIGNED (MM/DD/YYYY)

20C. ACCREDITATION NUMBER	20D. DATE LAST VA FORM 21-22 OR VA FORM 21-22A WAS SUBMITTED (If known)

PRIVACY ACT NOTICE: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in VA system of records, 58VA21/22/28, Compensation, Pension, Education and Veteran Readiness and Employment Records - VA, published in the Federal Register. Completion and submission of this form is voluntary. However, the requested information is important to assist VA in thoroughly researching your military record and other sources to obtain supporting evidence of traumatic event(s) in service. The responses you submit are considered confidential (38 U.S.C. 5701).

RESPONDENT BURDEN: An agency may not conduct or sponsor, and a person is not required to respond to a collection of information unless it displays a currently valid OMB control Number. The OMB control number for this project is 2900-0659, and it expires 03/31/2027. Public reporting burden for this collection of information is estimated to average 45 minutes per respondent, per year, including the time for reviewing instructions, searching existing data sources, gathering and maintaining the data needed, and completing and reviewing the collection of information. Send comments regarding this burden estimate and any other aspect of this collection of information, including suggestions for reducing the burden to VA Reports Clearance Officer at **VACOPaperworkReduAct@VA.gov**. Please refer to OMB Control No. 2900-0659 in any correspondence. Do not send your completed VA Form 21-0781 to this email address.