Initial Interview Form

If you are a veteran or a veteran's family member, you may be entitled to veterans' benefits. The following questions will help you and your advocate organize the information you need to apply for benefits. If additional room is needed to complete an answer, please attach a separate piece of paper. Do not send this form to the VA; give it to your accredited service officer.
Date _____

(1) Name of veteran: _____
First Middle Last

(2) Name used in service if different: _____

(3) Applicant if other than the veteran:
_____
First Middle Last

(4) Relationship to veteran: _____

(5) Address: _____
Number Street Apt. No.
_____
City State Zip Code

(6) Mailing address: _____
Number Street Apt. No.
_____
City State Zip Code

(7) Telephone:
Home ( ) _____
Work ( ) _____
Email address: _____

(8) Date of birth: ____/____/____
Month Day Year

(9) Social Security number: ___-__-____

(10) Single( ) Married( ) Separated( ) Divorced( ) Widowed( )

(11) Education:
Grade school( ) High school graduate: yes( ) no( )
If no, highest grade completed ____ GED: yes( ) no( )

College: yes( ) no( ) If yes, type of degree _____ Major(s): _____
If no college degree, semester hours completed: _____
Subject(s): _____
Vocational school: yes( ) If yes, type _____
Certificate type awarded: _____
Other education/training: _____

If you are not yourself a veteran, and your application is based on the eligibility of a veteran who is a member of your family--your spouse or your parent, for example--please answer the questions below as if you were the veteran.

(12) Are you currently employed? yes( ) no( )
If yes, what is your occupation? _____

(13) If not employed, are you able to work? yes( ) no( )

(14) If you are not employed, is it because of medical problems related to your military service? yes( ) no( )

(15) Are you receiving Social Security Disability, Supplemental Social Security, or other forms of government assistance? If you are, please specify:

_____

(16) Do you have dependents?
yes( ) no( )
If yes, how many? _____

Please list your dependents' names, how they are related to the veteran, dates of birth, and Social Security numbers:

_____
_____Information Related to Service

(17) Are you a veteran of the U.S. armed forces?
yes( ) no( )

If you are a veteran, please attach a copy of your discharge form, the DD 214. If you do not have a copy of your DD 214, please obtain from your advocate and complete and attach Standard Form (SF) 180, Request Pertaining to Military Records, to obtain a copy of your DD 214.

(18) To what branch of the service (army, navy, air force, marines, coast guard, merchant marine) did you belong?

_____

(19) In what era (Korea, Vietnam, Persian Gulf, OEF/OIF, or other) was your service?

_____

(20) Please list your dates of service:
Entry _____ Discharge _____
Entry _____ Discharge _____
Entry _____ Discharge _____

(21) Please state your type of discharge:
_____

(22) Were you discharged because of the completion of your obligation( ), downsizing( ), physical disability( ), or other reason? If other, please specify:
_____

(23) Are you receiving retirement pay from the military?
yes( ) no( )
If yes, please specify monthly amount: _____

(24) Are you receiving disability pay from the military?
yes( ) no( )
If yes, please specify monthly amount: _____

(25) Did you receive severance pay at discharge?
yes( ) no( )
If so, please specify amount received: _____

(26) Were you in combat?
yes( ) no( )

(27) Were you wounded?
yes( ) no( )
If so, where on the body?
_____

(28) Are you still having medical problems caused by the wound(s)?
yes( ) no( )
If so, what are the problems?
_____ _____

(29) Were you ever a prisoner of war?
yes( ) no( )
If yes, where and for how long?
_____
_____

(30) Do you have recurring dreams or intrusive memories about combat or your POW experience?
yes( ) no( )

(31) Do you have recurring dreams or intrusive memories about any traumatic experience during military service (one that involved feelings of intense fear, helplessness, or horror)?
yes( ) no( )

(32) Do you avoid, or react unusually to, things that symbolize or remind you of a traumatic event in service?
yes( ) no( )

(33) Were you treated for any injury, disability, or disease in service?
yes( ) no( )
If yes, briefly describe the disability or disease.

_____
_____

(34) Are you currently having problems with these same disabilities or diseases?
yes( ) no( )
If yes, briefly describe the problems. Be sure to describe how your disability interferes with your work:

_____
_____

(35) Did you suffer from a disease or injury in service that was not treated by a doctor?
yes( ) no( )
If so, describe:

_____

(36) Do you currently have a disease or injury that existed before your entry into service?
yes( ) no( )
If yes, describe:

_____ _____

(37) Did the disease or injury increase in severity (get worse) during service?
yes( ) no( )

(38) Are you currently suffering from a disability or disease whose symptoms appeared within one year after discharge from service?
yes( ) no( )
If yes, describe:

_____

(39) While in the service, were you exposed to:

radiation	yes( )	no( )
Agent Orange	yes( )	no( )
asbestos	yes( )	no( )
toxic chemicals	yes( )	no( )

nerve gas yes( ) no( )
depleted uranium yes( ) no( )
smoke from burning oil wells yes( ) no( )
other yes( ) no( )
If you answered "other," please describe:

_____

Information Related to VA Benefits

(40) Have you ever applied for VA benefits?
yes( ) no( )
If yes, check all that apply:
( )Compensation ( )Pension
( )Medical care ( )Education
( )Vocational rehabilitation ( )Nursing home care
( )Domiciliary care ( )Home loan guaranty
Other (please specify): _____
If this is a new claim, ask your advocate about filing an informal claim.

(41) If you have filed a claim before, please give the claim number that the VA assigned: ____
_____

(42) Are you now receiving VA benefits?
yes( ) no( )
If yes, check all that apply:
( )Compensation ( )Pension
( )Pension plus aid and attendance benefit
( )Pension plus housebound benefit
( )Medical care ( )Education
( )Vocational rehabilitation ( )Nursing home care
( )Domiciliary care ( )Home loan guaranty
Other (please specify): _____

(43) At which VA regional office is your claim file located?

_____

(44) Were you ever treated at a VA medical center?
yes( ) no( )
If yes, please specify when, where, and what the treatment was for:

_____

_____

(45) Have you ever sought counseling or help from a Vet Center?
yes( ) no( )
If yes, please specify when and where:

_____

(46) Are you now being treated, or have you been treated in the past, by a private physician for an illness or disability incurred in or aggravated by service?

yes( ) no( )

If yes, provide the date(s) on which you were treated and the name and address of the physician:

_____

_____

(47) Are you currently being treated or have you ever been treated at a hospital for an illness or disability incurred in or aggravated by service?

yes( ) no( )

If yes, provide the date(s) you were treated and the name and address of the physician:

_____

_____

(48) List any other information or comments that may be helpful:

_____

_____

(49) List all current disabilities:

_____

_____