FALLS PSYCHOLOGY SERVICES PLLC

FORENSIC MENTAL HEALTH NEXUS & RATE INCREASE INTAKE PACKET

VA DISABILITY PSYCHOLOGICAL EVALUATION

IMPORTANT INFORMATION

This packet is intended to assist in gathering comprehensive psychological, medical, occupational, social, and functional information relevant to VA disability evaluations, nexus opinions, DBQs, rate increase evaluations, and secondary medical opinions.

Please answer all questions honestly and thoroughly. The VA evaluates not only diagnoses, but also:

- Severity of symptoms
- Frequency and duration of symptoms
- Functional impairment
- Occupational impact
- Social/interpersonal impact
- Behavioral changes over time
- Relationship between service-connected and secondary conditions

The most helpful answers include SPECIFIC EXAMPLES rather than brief yes/no responses.

Example:

Instead of:

“I isolate.”

Please describe:

“I stopped going to family events because I become anxious, overwhelmed, irritable, and emotionally exhausted around crowds.”

You may attach additional pages if needed.

SECTION I

IDENTIFYING INFORMATION

Full Name: ____

DOB: ____

VA File Number / SSN Last 4: ______________________

Phone Number: ____________________________________

Email Address: ___________________________________

Current Address: _________________________________

Emergency Contact: _______________________________

Relationship Status:

☐ Single ☐ Married ☐ Divorced ☐ Separated ☐ Widowed ☐ Partnered

Children: ____

SECTION II

MILITARY HISTORY

Branch of Service: _________________________________

Dates of Service: __________________________________

MOS / Job Duties: __________________________________

Rank at Discharge: _________________________________

Type of Discharge: _________________________________

Deployments / Duty Stations:

Did you experience any of the following during service?

☐ Combat exposure
☐ Fear for your life
☐ Incoming fire
☐ Mortar/rocket attacks
☐ Military sexual trauma (MST)
☐ Harassment/bullying
☐ Toxic leadership
☐ Assault
☐ Serious accident
☐ Injury
☐ Witnessing injury/death
☐ Medical trauma
☐ Chronic stress/fear-based environment
☐ Discrimination
☐ Suicide exposure
☐ Other trauma

Please describe the MOST traumatic or distressing event(s) during service (if any):

How did you change emotionally or behaviorally after these events?

Did anyone notice changes in you during or after service?

☐ Family
☐ Friends
☐ Spouse/partner
☐ Coworkers
☐ Supervisors
☐ Fellow service members

Please explain:

Did any of the following increase during or after service?

☐ Alcohol use
☐ Drug use
☐ Isolation
☐ Anger/irritability
☐ Anxiety
☐ Depression
☐ Sleep problems
☐ Weight gain/loss
☐ Legal problems
☐ Relationship problems
☐ Work problems
☐ Panic attacks
☐ Emotional numbness
☐ Hypervigilance
☐ Suicidal thoughts

Please explain:

____

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SECTION III

CURRENT MENTAL HEALTH SYMPTOMS

Please check symptoms you currently experience:

☐ Anxiety
☐ Panic attacks
☐ Depression
☐ Emotional numbness
☐ Irritability/anger
☐ Hypervigilance
☐ Intrusive memories
☐ Nightmares
☐ Flashbacks
☐ Avoidance
☐ Startle response
☐ Sleep problems
☐ Racing thoughts
☐ Difficulty concentrating
☐ Memory problems
☐ Fatigue
☐ Low motivation
☐ Social isolation
☐ Trust issues
☐ Crying spells
☐ Hopelessness
☐ Guilt/shame
☐ Emotional shutdown
☐ Mood swings
☐ Dissociation
☐ Suicidal thoughts
☐ Self-harm thoughts
☐ Obsessive thoughts
☐ Feeling detached from others
☐ Feeling emotionally "flat"

What symptoms affect you the MOST?

____

____

Describe a recent example of your symptoms interfering with your functioning:

____

____

____

How often do your symptoms interfere with daily functioning?

☐ Daily
☐ Multiple times per week
☐ Weekly
☐ Occasionally

What situations trigger your symptoms?

____

____

____

SECTION IV

OCCUPATIONAL FUNCTIONING

Current Employment Status:

☐ Full-time
☐ Part-time
☐ Self-employed
☐ Retired
☐ Unemployed
☐ Unable to work
☐ VA TDIU

Current Occupation: _______________________________

How do your symptoms affect work?

☐ Difficulty concentrating
☐ Irritability/conflict
☐ Missed work
☐ Panic/anxiety at work
☐ Difficulty with supervisors
☐ Difficulty with coworkers
☐ Difficulty with the public
☐ Fatigue/exhaustion
☐ Poor motivation
☐ Reduced reliability/productivity
☐ Difficulty adapting to stress
☐ Memory problems
☐ Emotional shutdown
☐ Need excessive accommodations
☐ Need flexible schedule
☐ Unable to tolerate full-time work
☐ Difficulty maintaining employment

Describe your worst work-related mental health difficulties:

Have you ever:

☐ Been fired
☐ Quit due to symptoms
☐ Been written up
☐ Had attendance issues
☐ Had panic attacks at work
☐ Had conflicts with supervisors/coworkers
☐ Needed accommodations
☐ Reduced hours because of symptoms

Please explain:

If you currently work, what allows you to continue working despite your symptoms?

What would happen if you had a high-pressure or highly social job?

SECTION V

SOCIAL & RELATIONSHIP FUNCTIONING

Describe your current social life:

Do you isolate or avoid people?

☐ Yes ☐ No

Please describe examples:

How have your relationships changed over time?

Do you experience:

☐ Emotional detachment
☐ Difficulty trusting others
☐ Difficulty communicating
☐ Anger/irritability
☐ Emotional shutdown
☐ Avoidance of crowds/public
☐ Loss of hobbies/interests
☐ Difficulty with intimacy
☐ Parenting stress
☐ Hyperfocus on safety
☐ Fear of others
☐ Difficulty making friends

Have your symptoms contributed to:

☐ Divorce/separation
☐ Family conflict
☐ Loss of friendships
☐ Social withdrawal
☐ Relationship strain

Please explain:

SECTION VI

SLEEP, INSOMNIA, & HYPERAROUSAL

Do you have difficulty sleeping?

☐ Falling asleep
☐ Staying asleep
☐ Nightmares
☐ Waking in panic
☐ Racing thoughts
☐ Hypervigilance at night
☐ Sleeping lightly
☐ Waking frequently
☐ Non-restorative sleep
☐ Daytime fatigue
☐ Snoring
☐ Witnessed breathing pauses
☐ Gasping/choking at night
☐ Restless sleep
☐ Sleepwalking/talking

How many hours do you sleep on average?

Describe your sleep difficulties:

Have you been diagnosed with sleep apnea?

☐ Yes ☐ No

If yes:

Date diagnosed: ___________________________________

CPAP prescribed? ☐ Yes ☐ No

Do you use CPAP regularly?

☐ Yes ☐ No ☐ Sometimes

How does poor sleep affect your mood/functioning?

Do you use alcohol or substances to help sleep?

☐ Yes ☐ No

Please explain:

SECTION VII

CHRONIC PAIN & MEDICAL CONDITIONS

List all diagnosed medical conditions:

Do you experience chronic pain?

☐ Yes ☐ No

Where?

How does pain affect your mental health?

How does pain affect your sleep?

Do you believe your medical conditions worsen your:

☐ Anxiety
☐ Depression
☐ Sleep problems
☐ Irritability
☐ Fatigue
☐ Concentration
☐ Social functioning
☐ Sexual functioning
☐ Quality of life

Please explain:

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SECTION VIII

SECONDARY CONDITIONS SCREENING

Please check any conditions you currently have:

☐ Obstructive sleep apnea (OSA)
☐ Migraines/headaches
☐ Erectile dysfunction
☐ IBS/GI problems
☐ GERD
☐ Hypertension
☐ Chronic fatigue
☐ Chronic pain
☐ Bruxism/TMJ
☐ Weight gain
☐ Sexual dysfunction
☐ Alcohol misuse
☐ Cannabis use
☐ Panic symptoms
☐ Cognitive difficulties
☐ Fibromyalgia
☐ Tinnitus
☐ Insomnia
☐ Other: _________________

How do these conditions affect your mood, sleep, stress, or functioning?

____

____

____

____

SECTION IX

SUBSTANCE USE / SELF-MEDICATION

Do you currently use:

☐ Alcohol
☐ Cannabis
☐ Prescription pain medication
☐ Illicit substances
☐ Nicotine/tobacco

Please describe:

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____

Why do you use these substances?

☐ Sleep
☐ Anxiety
☐ Emotional numbness
☐ Pain relief
☐ Stress reduction
☐ Social functioning
☐ To "shut brain off"
☐ To calm down

Have you experienced:

☐ DUI/DWI
☐ Rehab/treatment
☐ Legal problems
☐ Relationship problems
☐ Work problems
☐ Blackouts
☐ Physical altercations
☐ Withdrawal symptoms

Please explain:

SECTION X

SUICIDAL THOUGHTS / SAFETY

Have you ever experienced:

☐ Passive suicidal thoughts
☐ Active suicidal thoughts
☐ Suicide attempt(s)
☐ Self-harm thoughts
☐ Self-harm behaviors

Please explain:

Do you currently feel safe?

☐ Yes ☐ No

SECTION XI

VA FUNCTIONAL IMPAIRMENT WORKSHEET

Please check any statements that apply:

☐ Difficulty adapting to stressful circumstances
☐ Near-continuous anxiety/depression
☐ Disturbances of motivation and mood
☐ Difficulty establishing relationships
☐ Difficulty maintaining relationships
☐ Impaired impulse control
☐ Panic attacks
☐ Suspiciousness
☐ Chronic sleep impairment
☐ Mild memory loss
☐ Impaired concentration
☐ Emotional withdrawal
☐ Flattened affect
☐ Isolation
☐ Difficulty functioning around crowds
☐ Difficulty functioning around authority figures
☐ Difficulty functioning around the public
☐ Hypervigilance
☐ Neglect of personal hygiene
☐ Obsessional rituals
☐ Passive suicidal ideation
☐ Persistent anxiety
☐ Persistent depression
☐ Emotional numbness
☐ Reduced reliability/productivity
☐ Deficiencies in most areas of functioning
☐ Total occupational/social impairment

Please describe how your symptoms impair your daily functioning:

SECTION XII

CURRENT TREATMENT

Current therapist/psychiatrist:

Current medications:

Past psychiatric hospitalizations:

Current VA treatment:

Have you ever stopped treatment because of:

☐ Avoidance
☐ Stigma
☐ Anxiety
☐ Transportation
☐ Distrust
☐ Financial reasons
☐ Feeling emotionally overwhelmed

Please explain:

SECTION XIII

SUPPORTING DOCUMENT CHECKLIST

Please upload/provide copies of:

☐ DD214
☐ VA rating decisions
☐ Prior denial letters
☐ Sleep studies
☐ DBQs
☐ Therapy records
☐ Psychiatric records
☐ Medication lists
☐ Buddy statements
☐ Spouse/family statements
☐ Lay statements
☐ Disciplinary records
☐ Performance evaluations
☐ Medical records
☐ Imaging/lab reports
☐ CPAP compliance reports
☐ Other supporting evidence

FINAL STATEMENT

Is there anything else you believe is important for Dr. Bodine-Smith to understand about your mental health symptoms, military experiences, sleep problems, chronic pain, or functioning?

CERTIFICATION

I certify that the information provided in this packet is true and accurate to the best of my knowledge.

Signature: ______________________________________

Date: ____