VETERAN INTAKE FORM

This form is designed to help us better understand your military service and the injuries you have sustained due to said service. The information you provide will be used to support individual VAC claims, so please be specific and detailed. If there is information of your service that you want/need to share with the Veteran Coordinator and/or Nurse Practitioner but are not comfortable providing it to VAC directly, please use the comments section at the bottom of the page. Your general well-being is our first priority and we want to respect your personal boundaries when it comes to disclosing your confidential information, especially when working with VAC.

If you have any questions or concerns, please do not hesitate to reach out to our Veteran Coordinator, Katelyn Lomax, at vetassistance@yourmedicalhome.ca

Thank you, and have an amazing day!

PERSONAL/CONTACT INFORMATION

First Name: _____ **Last Name:** _____

Birth Date: _____ **K#/Service #:** _____

Email: _____ **Phone:** _____

Address: _____ **AHC #:** _____

Marital Status:

- ☐ Single
- ☐ Married
- ☐ Common-law
- ☐ Separated
- ☐ Divorced
- ☐ Widowed

Do you have any dependents? ☐ **Yes** ☐ **No**

If so, how many? _____

SERVICE INFORMATION

What years did you serve in the military? _____

What was your release item? ☐ **Voluntary** ☐ **Medical**

What was your trade(s)? _____

Do you have any deployments? ☐ **Yes** ☐ **No** **If so, where?** _____

INJURY/MEDICAL INFORMATION

The following questions are designed to help us better understand your military career and thus be able to assist with your needs. Please complete the following questions in as much detail as possible (dates, years, etc.).

- **What injuries did you sustain while in service?** Elaborate with details (what year did it happen? Was it reported? Was surgery required? Did you do any additional rehabilitation for the injury at the time?) Any repetitive stressors? (i.e. Carrying ruck sack, jumping out of ML, exposure to high-frequency jammers, etc.).

- **Please describe your pain:** Where is the pain? Please list if your pain is felt every day or if it is intermittent. Please rank the pain on a scale of 1 to 10, at rest and with activity.
  - **Sample Description:** 1. Right knee - everyday pain, at rest = 7, with activity = 9

- **List ALL your medications** (including over the counter, prescribed, and herbal supplements. Please keep in mind that cannabis (CBD/THC) is medicine as well.)
- **How often do you take the medicine? What are the doses?**

INJURY/MEDICAL INFORMATION

- **Please list all surgeries** - including dates (year is fine)

Are you currently involved in any treatments?

- ☐ **Physiotherapy**
- ☐ **Massage Therapy**
- ☐ **Chiropractor**
- ☐ **Psychologist**
- ☐ **Cannabis**
- ☐ **Psychiatrist**
- ☐ **I am not involved in any treatments**
- ☐ **Other:** _____

- **If you are doing any treatment, are they helping with your symptoms? Please explain and provide the name of the provider.**
  - **Example:** 1. Chiropractor, somewhat reducing symptoms, Dr. Michael Smith

I consent to the Nurse Practitioner sharing information/communicating with the services listed above to best coordinate my care.

☐ **Yes** ☐ **No**

SUPPORT/BENEFIT INFORMATION

We want to ensure that all personal and health factors are taken into account when coming up with an action plan. This section is VOLUNTARY. Under NO CIRCUMSTANCES will this information be release to VAC, it is to help assist us in caring for YOU!

Do you have a VAC account? ☐ **Yes** ☐ **No**

If yes, do you have a Case Manager? What is their name and contact number? _____

_____

Are you receiving any of the following benefits from VAC?

- ☐ Income Replacement Benefit (IRB)
- ☐ Disability Tax Credit (DTC)
- ☐ Additional Pain & Suffering Compensation (APSC)
- ☐ Rehabilitation/ PCVRS (Partners in Canadian Veteran Rehab Services)
- ☐ Disability Benefits
- ☐ Career Transition/ Education & Training Benefit
- ☐ Caregiver Recognition Benefit
- ☐ Veteran Independence Program (VIP)
- ☐ None
- ☐ Other: _____

PERSONAL WELL-BEING

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Do you use any socio-economic supports?

- ☐ Education
- ☐ Food Supports
- ☐ Housing
- ☐ Financial Supports
- ☐ None
- ☐ Other: _____

Please rank the top 3 stressors in our life. (i.e. death of a loved one/friend, marital problems (divorce, separation), incarceration, personal injury or illness (physical, mental), dependents/child-care, finances, housing, work, etc.).

PERSONAL WELL-BEING

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For each question please choose from the following alternatives:
0 - Never 1 - Almost never 2 - Sometimes 3 - Fairly often 4 - Very often

	0	1	2	3	4
In the last month, how often have you felt nervous and stressed?	☐	☐	☐	☐	☐
In the last month, how often have you felt confident about your ability to handle your personal problems?	☐	☐	☐	☐	☐
In the last month, how often have you found that you could not cope with all the things that you had to do?	☐	☐	☐	☐	☐
In the last month, how often have you been able to control irritations in your life?	☐	☐	☐	☐	☐
In the last month, how often have you been angered because of things that happened that were outside of your control?	☐	☐	☐	☐	☐
In the last month, how often have you felt that you were on top of things?	☐	☐	☐	☐	☐

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For each statement please choose from the following alternatives:
0 - Never 1 - Seldom 2 - Sometimes 3 - Often 4 - Almost Always

	0	1	2	3	4
I feel supported by my friends and family.	☐	☐	☐	☐	☐
I feel supported and listened to by my doctors/health care team.	☐	☐	☐	☐	☐
When experiencing mental and/or physical distress, I know I have a support system to turn it.	☐	☐	☐	☐	☐
I tend to distance myself from friends and family.	☐	☐	☐	☐	☐
I have personal interests/ hobbies that I partake in regularly.	☐	☐	☐	☐	☐
I feel like my mental and/or physical health conditions isolate me.	☐	☐	☐	☐	☐

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What specific actions or communication approaches do you believe would contribute to a greater sense of support from your healthcare team?

ADDITIONAL NOTES & COMMENTS

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Additional information, comments, questions, and/or concerns:

Please bring any of the following documents that you may have to your appointment:

1. Summary of Assessment - This may be found on your MyVAC account oy by contacting your case manager.
2. Any diagnostic imaging - Xrays, ultraspunds, MRI's, etc.
3. Any lab work
4. Medication List
5. Any previous History/ Medical Documents
6. CAF Proof of Vaccine Credentials (yellow book)

PLEASE EMAIL COMPLETED FORM TO VETASSISTANCE@YOURMEDICALHOME.CA