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PROVIDING:
ELDER LAW SERVICES
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VA BENEFITS PLANNING
FAMILY LAW SERVICES
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MEDIATION SERVICES
SOCIAL SECURITY DISABILITY APPEALS

CONFIDENTIAL CLIENT QUESTIONNAIRE for VA COMPENSATION BENEFITS

This questionnaire is intended to elicit the basic information we need to help you with your claim for service-connected compensation benefits for the Department of Veterans Affairs (VA). **All information will be held in the strictest confidence.**

Today's Date ________________

1. Name: ____
Address: ____
Phone No: ____
Date of birth: ________________ Place of birth: ________________________

2. Name, address and phone number of someone we can contact if we cannot find you:
____
____

3. Social Security Number: ____

4. C-File # and Regional Office location: ____

5. Service #: ________________ Branch of Service: ________________________
Date of Entrance: ________________ Date of Discharge: ________________________

6. Name, address and birth date of spouse: ____
____
____

Date and place of marriage: ____

Names, addresses and birth dates of children (including natural and stepchildren): ________________
____
____
____
____
____

(For a Service-Connection claim only: Please provide copies of birth certificates for all your dependent children, and a copy of your marriage certificate)

Names, addresses and birth dates of dependent parents: ____
____
____

7. Sources of income:

Employment: Full-Time____ Part-Time____

Social Security Disability Income (SSDI) amount: _________________Date began: ___________________
For what disability: ______________________

Supplemental Security Income (SSI) amount: ____________________Date began: ___________________
For what disability: ______________________

Pensions:
Government: ____
Amount: ___________________________________ Date began: ______________________________
Private: ____
Amount: ___________________________________ Date began: ______________________________

Disability Insurance:
Amount: ___________________________________ Date began: ______________________________

Agent Orange
Amount: ___________________________________ Date began: ______________________________

Public Assistance:
Amount: ___________________________________ Date began: ______________________________

Worker's Compensation:
Amount: ___________________________________ Date began: ______________________________

Any other source of income (e.g., child support, spouse's income): _________________________________
____

8. Have you ever been declared incompetent?
a. Criminal proceeding: ____
b. By VA: ____
c. Civilly - guardian/conservator appointed? ____
If so, when: ____
Still in effect: Yes____ No____
Name, address and phone no. of guardian/conservator: ____
____

9. Have you ever been convicted of a felony? When, where, period of incarceration: _________________
____
____

Date of release from incarceration: ____

SERVICE-CONNECTION DATA FORM
(Fill Out Completely)

1. Name: ____

2. BRANCH OF MILITARY SERVICE — DATES OF SERVICE

______________________________ ______________

______________________________ ______________

______________________________ ______________

______________________________ ______________

3. Please give your military occupational specialty (MOS).

4. Was any portion of your service involved in combat with the enemy? Yes _____ No _____ If so, please describe the nature of your involvement and how it related to your military occupational specialty.

5. Please give the dates or general time periods in which the circumstances described in answer #4 occurred (Please be as specific as possible)

6. Do you currently know the whereabouts of any individual who served with you who would be able to verify or corroborate your involvement in combat? Yes _____ No _____ If so, please provide name and address.

7. Do you have any of the following medals or awards? Yes _____ No _____ If so, indicate which ones. If so, please list those medals.

___ Air Force Cross
___ Army Commendation Medal with 'V' Device
___ Combat Action Ribbon
___ Distinguished Flying Cross
___ Distinguished Service Cross
___ Medal of Honor
___ Navy Cross
___ Purple Heart
___ Air Force Medal with "V" Device
___ Bronze Star Medal with 'V' Device
___ Combat Infantryman Badge
___ Combat Medical Badge
___ Joint Service Commendation Medal
___ Navy Commendation Medal
___ Silver Star

8. Please state the character of your discharge from each period of service you received a DD214 and the dates for each period of service, beginning and ending.

9. Were you discharged from the service due to medical reasons? If so, do you have copies of those records?

10. Has your discharge ever been upgraded? If yes, when, and from what to what?

11. Describe the nature of your current disability or disabilities.

12. Please describe the circumstances during service upon which you believe your current disability is based.

13. If you experienced only symptoms during service and received no diagnosis of your current disability, please describe those symptoms.

14. If you were treated for any of the symptoms of your current disability during service, please provide the date and source of that treatment.

15. If you were not treated for these symptoms, did you at the time tell any person that you were experiencing these symptoms? If you did, please identify the person(s), the symptoms observed and the time frame.

16. Do you recall any person either commenting on or observing and discussing these symptoms with you? If you do, please identify the person(s), the symptoms observed and the approximate time frame.

17. Did you receive a diagnosis of any disability, disease or condition during service?

18. Please provide the dates of any treatment you received for the claimed disability, disease or condition during service.

19. Please list the locations of treatment you received in service, including facility name, city, state and/or country.

20. Do you have in your possession copies of any of your service medical records? If so, please provide copies to this office.

21. What was the nature of treatment you received in service? Inpatient, Outpatient, Sick Call or other? If other, please be specific.

22. Do you suffer from any other conditions or disabilities which a medical person has indicated are proximately due to or the result of your claimed service connected condition or an existing service connected condition? (Please identify these conditions and the medical source.)

23. Did you receive any private medical treatment during service?

Date: ____
Address (Street, City, State, Zip Code) ____
____
____

Nature of treatment: ____
____

24. Describe any **symptoms** you had associated with the claimed disability within one year of service; please provide dates.

25. Please list the names and addresses of persons who would be able to confirm or verify symptoms within one year of discharge (can be family physician, spouse, children, parents, other relatives, friends, employers, coworkers).

26. Were you treated for, diagnosed or otherwise told that you suffered from the in-service disease or condition? If so, please provide dates and sources of medical treatment.

27. Was the condition you suffered in-service noted at your entrance exam? Yes ____ No ____

28. Did you inform the military of any disease, disability or injury which you had experienced prior to service? Yes ____ No ____

29. Did your pre-service condition increase in severity during service? If so, describe how.

30. Please provide the treatment history for your disability/disabilities.

Please list all **Inpatient Treatment** you have received for your disability/disabilities since discharge from service:

Date: _____________________________ Hospital: ____________________________
Address (Street, City, State, Zip Code) ____
____

Briefly Describe Your Treatment (e.g., type of therapy):______________________________

____

Date: ____________________ Hospital: ______________________
Address (Street, City, State, Zip Code) ______________________________

____

Briefly Describe Your Treatment (e.g., type of therapy):______________________________

____

Date: ____________________ Hospital: ______________________
Address (Street, City, State, Zip Code) ______________________________

____

Briefly Describe Your Treatment (e.g., type of therapy):______________________________

____

Date: ____________________ Hospital: ______________________
Address (Street, City, State, Zip Code) ______________________________

____

Briefly Describe Your Treatment (e.g., type of therapy):______________________________

____

Date: ____________________ Hospital: ______________________
Address (Street, City, State, Zip Code) ______________________________

____

Briefly Describe Your Treatment (e.g., type of therapy):______________________________

____

Date: ____________________ Hospital: ______________________
Address (Street, City, State, Zip Code) ______________________________

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Briefly Describe Your Treatment (e.g., type of therapy):______________________________

____

Date: ____________________ Hospital: ______________________
Address (Street, City, State, Zip Code) ______________________________

____

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Date: ________________________________ Hospital: ____
Address (Street, City, State, Zip Code) ____
____

Briefly Describe Your Treatment (e.g., type of therapy):____
____

Date: ________________________________ Hospital: ____
Address (Street, City, State, Zip Code) ____
____

Briefly Describe Your Treatment (e.g., type of therapy):____
____

Date: ________________________________ Hospital: ____
Address (Street, City, State, Zip Code) ____
____

Briefly Describe Your Treatment (e.g., type of therapy):____
____

Date: ________________________________ Hospital: ____
Address (Street, City, State, Zip Code) ____
____

Briefly Describe Your Treatment (e.g., type of therapy):____
____

Date: ________________________________ Hospital: ____
Address (Street, City, State, Zip Code) ____
____

Briefly Describe Your Treatment (e.g., type of therapy):____
____

Date: ________________________________ Hospital: ____
Address (Street, City, State, Zip Code) ____
____

Briefly Describe Your Treatment (e.g., type of therapy):____
____

Date: ________________________________ Hospital: ____
Address (Street, City, State, Zip Code) ____
____

INCREASED DISABILITY RATING DATA FORM

(Fill Out Completely)

1. What are your service-connected conditions?

DISABILITY	RATING	DATE BEGAN

2. What is the date of your original service-connected claim? ___________________________________

3. For what condition(s) are you seeking an increased disability rating?___________________________
____

4. Have you been awarded Social Security benefits? Yes ___ No____ If yes, date awarded: __________

If awarded Social Security benefits, was the disabling condition the same as your service-connected condition? Yes ___ No ___

If no, for what conditions were you awarded Social Security benefits? ___________________________
____

5. **Inpatient Treatment** Received for Your Service-Connected Disability: _______________________
____

Date: ____________________________________ Hospital: __________________________________
Address (Street, City, State, Zip Code): ____
____

Disability: ____
____

Date: ____________________________________ Hospital: __________________________________
Address (Street, City, State, Zip Code): ____
____

Disability: ____
____

Date: ______________________________ Hospital: ______________________________
Address (Street, City, State, Zip Code): ______________________________
____

6. **Outpatient Treatment** Received for Your Service-Connected Disability: ______________
____

Date: ______________________________ Hospital: ______________________________
Address (Street, City, State, Zip Code): ______________________________
____

Disability: ______________________________
____

Date: ______________________________ Hospital: ______________________________
Address (Street, City, State, Zip Code): ______________________________
____

Disability: ______________________________
____

Date: ______________________________ Hospital: ______________________________
Address (Street, City, State, Zip Code): ______________________________
____

7. Employment History:

Date Last Employed: From: ____________________ To: ____________________
Employer: ______________________________

Date: From: ____________________ To: ____________________
Employer: ______________________________

Date: From: ____________________ To: ____________________
Employer: ______________________________

INTAKE INFORMATION FOR EARLIER EFFECTIVE DATE (EED) CLAIMS FOR TOTAL RATINGS

1. Date: ______________________________

2. Name: ______________________________
Address: ______________________________
Phone #: ______________________________

Referred by: ______________________________
Name: ______________________________
Address: ______________________________
Phone #: ______________________________

3, Vet contacted us by phone? _________ Vet contacted us by letter? ________

4. Current service-connected rating(s) for all conditions:

5, When did you get your total disability rating:

6, Do you have a pending claim on EED? Yes ___ No ___ If yes, status:

7. Prior Claim History:

1. Date of original claim:

2. Recd RD?

3. Date of NOD:

4. Rec'd SOC?

5. Date of VA9:

6. BVA decision?

8. Receiving SSDI Benefits? Yes ___ No ___ For what disability are you receiving SSDI benefits? ____

9. If receiving SSDI benefits and it is for the same condition as you are SC, did you put the VA on notice that you are in receipt of SSDI benefits? Yes ___ No ___

If not receiving SSDI benefits, when was the last time you worked full-time (40 hrs. wk/6 mos. or longer)?

10. When did you first receive VA treatment?

Dates of Service:
Branch:
MOS:
Foreign Service:
Discharge:
Decorations/Medals:

UNEMPLOYABILITY DATA FORM

NAME: ____

DATE: ____

1. Please describe the kind of work you have done since you left the service. Specifically:

   a. Was it skilled or unskilled work?

   b. Describe any and all vocational training or special training you have for any type of work.

   c. From the time you left service to now, how many jobs have you had?

   d. When and where was the last time you worked full-time (40 hrs. a week for 6 uninterrupted months)?

2. Check off the problems you **regularly** have experienced on the job:

   a. Difficulty in concentrating . . . . ____

   b. Difficulty in performing tasks . . . . ____

   c. Difficulty in completing tasks . . . . ____

   d. Difficulty in receiving, understanding or following instructions . . . . ____

   e. Difficulty with co-workers . . . . ____

   f. Difficulty with supervisors . . . . ____

   g. Explosive behavior . . . . ____

   h. Physical confrontation or violence on the job . . . . ____

   i. Intrusive thoughts while on the job . . . . ____

   j. Flashbacks on the job . . . . ____

   k. Hallucinations (auditory) on the job . . . . ____

   l. Hallucinations (visual) on the job . . . . ____

   m. Memory difficulties . . . . ____

   n. Homicidal feelings . . . . ____

   o. Suicidal feelings . . . . ____

3. Has your disability caused you to lose time at work? If so, please describe the frequency of work missed:

a. One day a week: ____

b. One week a month: ____

c. One month out of three mos.: ____

d. Other (please describe): ____
____

4. Does your condition require you to be hospitalized regularly? Yes ____ No ____
If yes, how often?

5. What is the most money you ever made in a single calendar year (approximately amount)

6. What is the longest time you have gone without a job?

7. What is the longest time you have held a job?

8. At your place of employment, were you ever provided any special considerations because of your disability? Yes ____ No ____ If yes, please describe (e.g., allowed breaks, etc.)

9. Please describe why you left your most recent job:

10. Is the description of why you left your job typical reasons for leaving your prior employments?

EMPLOYMENT HISTORY PAST TEN YEARS

NAME: ____ DATE: ______________________

Employer: ____
Dates: ____ Rate of Pay: __________________

Reasons for leaving: ____
____

Nature of Work Performed: ____
____
____ Hours Per Week: ____________________

Employer: ____________________
Dates: ____________________ Rate of Pay: ____________

Reasons for leaving: ____________________
____

Nature of Work Performed: ____________________
____
____________________ Hours Per Week: ____________

Employer: ____________________
Dates: ____________________ Rate of Pay: ____________

Reasons for leaving: ____________________
____

Nature of Work Performed: ____________________
____
____________________ Hours Per Week: ____________

Employer: ____________________
Dates: ____________________ Rate of Pay: ____________

Reasons for leaving: ____________________
____

Nature of Work Performed: ____________________
____
____________________ Hours Per Week: ____________

Employer: ____________________
Dates: ____________________ Rate of Pay: ____________

Reasons for leaving: ____________________
____

Nature of Work Performed: ____________________
____
____________________ Hours Per Week: ____________

Employer: ____
Dates: ____________________________ Rate of Pay: ______________

Reasons for leaving: ______________________________________
____

Nature of Work Performed: _________________________________
____
______________________________________ Hours Per Week: __________

Employer: ____
Dates: ____________________________ Rate of Pay: ______________

Reasons for leaving: ______________________________________
____

Nature of Work Performed: _________________________________
____
______________________________________ Hours Per Week: __________

Employer: ____
Dates: ____________________________ Rate of Pay: ______________

Reasons for leaving: ______________________________________
____

Nature of Work Performed: _________________________________
____
______________________________________ Hours Per Week: __________

Employer: ____
Dates: ____________________________ Rate of Pay: ______________

Reasons for leaving: ______________________________________
____

Nature of Work Performed: _________________________________
____
______________________________________ Hours Per Week: __________

Is any other information I should be aware of? Yes ☐ No ☐ If yes, please explain: ____________________
____
____

REFERRAL

By whom were you referred to this office?
Name ____
Street Address____
City________________________________ State____________ Zip______
Referral is:
___ Attorney
___ Financial Planner
___ Previous Client of the Law Office of Donald D. Vanarelli
___ Other______________________________________
Have you visited our website at www.dvanarelli.com? Yes ☐ No ☐
If yes, do you have any ideas for improving our website? If so, please discuss. _____________________
____
____

CERTIFICATION

I understand that the recommendations and advice which you give, and any claim(s) and/or appeal(s) which you file, will be based on the accuracy and completeness of the disclosures made herein. **Thus, I certify that the information provided is true and correct in all respects to the best of my knowledge and belief.**

____ ____
Client **Client**