



The Place Within Counseling
530 Plaza Drive, Suite 130
Folsom, California 95630
(916) 799-1644



Veterans Empowered to Succeed
(VETS)

Name: _____ Date: _____

Significant Other's Name & Phone #: _____

Address: _____ City: _____ Zip: _____

Home Phone: _____ Cell: _____ Email: _____

If we call, can we identify ourselves as counselors from The Place Within? __ Yes __ No

Date of Birth: _____ Marital Status: _____

Gender: _____

How did you hear about The Place Within? _____

Emergency Contact Information: _____

Are you a veteran of the U.S. Armed Forces? Yes () No () Explain:

Are you currently employed? Yes () No () If yes, what is your occupation?

If not employed, are you able to work? Yes () No ()

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

Partner's Occupation: _____

Highest Education: 9th, 10th, 11th, 12th, some college, college, post grad

Current Medications:

Doctor's Name & Phone: _____

How would receiving scholarship/free counseling services benefit you? _____

Please describe why you feel you should be considered for a scholarship/free counseling? _____

What issues/concerns caused you to seek this program?

Have you sought counseling before? If yes, when and how long and was it beneficial?

What would you like to accomplish in this Group or Individual counseling?

What branch of the service (army, navy, air force, marines, coast guard, merchant marine, and reserve) did you belong?

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

Please list your dates of service:

Entry _____	Discharge _____
Entry _____	Discharge _____
Entry _____	Discharge _____

Please state your type of discharge: _____

What were your duties/positions in the military? _____

Were you in combat? Yes () No ()

Were you wounded? Yes () No () If so, where on the body?

Are you still having medical problems caused by the wound(s)? Yes () No () If so, what are the problems?

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

Were you ever treated at a VA hospital? Yes () No () If yes, please specify when, where, and what the treatment was for:

During your service did you ever experience fear of hostile military or terrorist activity? Yes () No ()

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

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 ()

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

Has a medical professional or mental health expert (a doctor or a psychologist, for example) diagnosed you as having PTSD? Yes () No ()

If you have been diagnosed as having PTSD, do you believe that it is linked to, or caused by, a stressful experience you suffered in service? Yes () No ()

Has a doctor told you that your PTSD was caused by service? Yes () No ()

Were you ever a prisoner of war? Yes () No () If yes, where and for how long?

Were you personally assaulted during service (personal assault includes but is not limited to rape, physical assault, domestic battering, robbery, mugging, and stalking)?
Yes () No ()

If yes, do you have recurring dreams or intrusive memories due to that experience: Yes
() No ()

Family History:

Mother's Name, living/deceased: _____

Father's Name, living/deceased: _____

Name & Ages of Siblings(include half & step):

Name & Ages of Children:

Alcohol Use (frequency/amount): _____

Drug Use (frequency/amount): _____

Religious/Spiritual Affiliation?

