Family Information Supplement

This information may ***only*** be filled out by a **spouse, significant other, or immediate family member** (*Father, Mother, Brother, Sister, or Adult Child*).

Post Traumatic Stress Residential Rehabilitation Program
Department of Veterans Affairs
Medical Center
Waco, Texas

Name of Veteran: _____

Address of Veteran: _____

City: _____ State: _____ Phone: ( ) _____

Date of Birth: _____ Birthplace: _____

Religion: _____ Marital Status: _____ Number of Dependents: _____

Usual Occupation: _____ Date of Last Employment: _____

Highest Education Completed: _____ Year: _____

Branch of Service: _____ Date of Service: _____

Sources of Income: *Please indicate amount of each.* VA Comp: _____

VA Pension: _____ Social Security: _____ Other *(please specify)*: _____

With Whom does the Veteran normally live? _____

Spouse's maiden name, Address, Age, Telephone number, and Occupation:

_____

_____

Number of marriages: _____ Date of present marriage: _____

If more than one marriage, please list each one and the length of that union: _____

_____

_____

Is the Veteran court committed? _____ Does the Veteran have a legal guardian? _____

If a guardian, please give name, address, telephone number, and type of each guardianship:

_____

_____

_____

_____

Please give name, address, telephone number, and relationship of two people to notify in the event of an emergency:

Please list name, address, and telephone number of Veteran's children:

Please list name, address, and telephone number of Veteran's brothers and sisters:

Father's name, address, age, telephone number, and occupation: (If deceased, please give cause and date of death)

Mother's name, address, age, telephone number, and occupation: (If deceased, please give cause and date of death)

Has the Veteran ever experienced the following? If so, please explain:

Serious Depression _____ Seizures _____

Hear Imaginary Voices _____ Blackouts _____

See Things That aren't there _____ Threaten to harm others _____

Talk of people being against him _____ Threaten to harm self _____

Actually attempt suicide (if so, when?) _____

Believe others are controlling his mind _____

Why do you feel the Veteran is seeking treatment at this particular time?

Did the veteran's behavior cause any problems in the family? If so, please explain.

Does the veteran have, or has he ever had, the following problems? If "Yes," please explain in the space below:

_____ Medical problems

_____ Financial problems

_____ Marital or family problems

_____ Court charges

_____ Alcohol abuse

_____ Drug Abuse

_____ Difficulty holding jobs

_____ Refusing to take prescribed medication

What were the Veteran's feelings about coming to the hospital?

What do you hope will be accomplished during this period of hospitalization?

Has the Veteran any family history of Diabetes, heart disease, cancer, or mental illness? If yes, please give details:

What social or recreational interests does the Veteran have?

When the Veteran is discharged from the hospital, with whom will he live?

Was the Veteran employed prior to hospitalization? Will he have a job to return to when he leaves the hospital?

Name of Person completing this form

Relationship to Veteran

Address, City & State, Zip Code

Date

Mail to: CTVHCS PTSD Program (116/PRRP)
4800 Memorial Drive
Waco, TX 76711