Veterans Affairs Canada | Anciens Combattants Canada

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File No.:	Decision No.:
Service No(s).:	

Medical Questionnaire: Psychiatric Conditions

Family name:	Given name:	Date of Birth:
Name of Physician/Psychologist:	Psychologist's Provincial Registration Number:	Date of Examination:

MEDICAL DIAGNOSIS(ES) (ACCORDING TO DSM CRITERIA) OF CONDITION(S) REQUIRING EXAMINATION:

Axis I _____

Axis II _____

Axis III _____

Axis IV _____ (Assessment of psychosocial environmental problems)

Axis V _____ (Global Assessment of Functioning score - current year)

_____ (Global Assessment of Functioning score - past year)

Is this diagnosis: ◯ confirmed or ◯ provisional?

Do you expect further medical improvement? ◯ Yes ◯ No

If yes, please specify and include time frame of expected improvement:

Very specific information is required by Veterans Affairs Canada to evaluate and assess a client's claimed pensioned condition(s). As this information may not generally form part of the clinical history, please help us to collect this information by answering the following questions.

Please complete applicable sections only.

If additional recording space is required, please use the "additional comments" sheet.

Please provide contributing/precipitating factors including any relationship between the psychiatric condition and military service.

Are further diagnostic tests or consultations ongoing/planned? ◯ Yes ◯ No

If yes, indicate the nature of the test/consultation, and the appointment date (if known):

PLEASE ATTACH/FORWARD COPIES OF RELEVANT REPORTS (E.G. DIAGNOSTIC, CONSULTATION, OPERATIVE, LABORATORY, HOSPITAL DISCHARGE SUMMARIES)

Family name:	Given name:	File No.:

For the purposes of this questionnaire, the following terms are to be used with regards to the frequency of signs and symptoms:

Rare - at least once per year
Occasional - once or twice per month
Frequent - at least once per week
Persistent - daily or almost daily

MEMORY AND CONCENTRATION

MMSE Score:

Short-term Memory:

Long-term Memory:

Concentration: Please report objective findings regarding any impairment of concentration. Please qualify with examples.

Amnestic Episodes: Describe and record the number of episodes.

THOUGHT AND PERCEPTION

Orientation Status: Indicate response to prompting, if applicable.

Speech/Thought: Please describe impairment of the client's speech/thought, if any (e.g. flow, content, connection of thoughts or ideas, coherence, etc.). Please qualify with examples.

Perceptual Disturbances: Please specify the type of disturbance(s) experienced, if any, and indicate the frequency of occurrence. Please qualify with examples.

Suspiciousness: Describe frequency, distractability, insight, etc.

Preoccupation(s): Describe

Recurrent Obsessions: Describe the length of occurence per day.

Delusion: Specify type of delusion, bizarre vs. non-bizarre, insight, etc. Describe frequency of occurence.

Family name:	Given name:	File No.:

Guilt and/or Survivor's Guilt: Describe

Sense of Loss of Control over Eating Behaviour: Describe

Distorted Perception of Body Shape and/or Weight: Describe

Suicide Ideation: Describe frequecy, plan(s), etc.

Homicidal Ideation: Describe frequency, plan(s), etc.

Other: Please describe any other impairment of thought or cognition. Please qualify with examples.

EMOTION AND BEHAVIOUR

Post-traumatic Stress Disorder:

A) Re-experiencing Phenomenon: (flashbacks, nightmares, intrusive recollections, etc.) Describe frequency.

B) Avoidance/Numbing: Describe frequency, nature and severity.

C) Hyperarousal: (hypervigilance, difficulty falling asleep or staying asleep, irritability or outbursts of anger, difficulty concentrating, exaggerated startle response) Describe frequency, nature and severity.

Family name:	Given name:	File No.:

Eating Disorder(s):

Maintenance of expected body weight:
◯ greater than 90% ◯ 85 - 90% ◯ 75 - 84% ◯ 70 - 74% ◯ less than 70%

Use of inappropriate compensatory methods to prevent weight gain:

Diet: Describe.

Depressive Symptoms: Describe frequency and severity of symptoms (depressed mood, vegetative symptoms).

Manic/Euphoric Symptoms: Describe frequency and severity of symptoms (euphoric mood, manic behaviour).

Dependence on others/Decision Making Ability: Describe:

Anxiety: Describe frequency, nervous behaviour such as pacing, and physiologic concomitants.

Panic Attacks: Describe frequency, intensity and associations with avoidance.

Obsessive/Compulsive Symptoms: Describe frequency, nature and life interference, etc.

Avoidance of Particular Events/Objects: Describe frequency, nature and life interference, etc.

Irritability/Anger: Describe frequency. Indicate physical/verbal abuse or agression, etc.

Lack of Empathy or Remorse: Describe

Sleep Disturbance: ◯ Yes ◯ No
If yes, what best describes the disturbance.
◯ insomnia, up to 120 minutes total loss of sleep most nights each week with daytime somnolence.
◯ greater than 120 minutes total loss of sleep most nights each week with daytime somnolence.
Comment:

Physical Health Concerns: Describe concerns, frequency and request for specific intervention.

Self-mutilating Behaviour: Describe and note frequency of occurence.

Suicide: Has the client attempted suicide? ◯ Yes ◯ No
Provide dates:

Homicide: Has the client attempted homicide? ◯ Yes ◯ No
Provide dates:

Family name:	Given name:	File No.:

Substance Abuse/Dependency:

Does the client exhibit evidence of a substance abuse and/or dependency problem at present? ◯ Yes ◯ No
Elaborate:

Has the client shown evidence of a substance abuse and/or dependecy problem in the past? ◯ Yes ◯ No
Elaborate:

Other: Describe any other impairment of emotion or behaviours.

COPING

Ability to Cope:

Describe the level of difficulty the client has in coping with stress in his work, at home or in his personal/social relationships. Include frequency.

Describe impulsive and unlawful behavoiur. Include frequency.

PHYSICAL EXAMINATION:

Height _____ Weight _____ Blood Pressure _____ Pulse _____ Respiration _____

GENERAL APPEARANCE:

EXAMINATION FINDINGS:

TREATMENT

Indicate current or recommended medication:

Indicate current or recommended therapy/counselling:

IF ADLs ARE AFFECTED ON A CONTINUOUS BASIS, DESPITE OPTIMAL TREATMENT, PLEASE COMPLETE THE ADL SECTION.

OTHER PERTINENT FINDINGS:
Please comment on any medical condition(s) that may be contributing to the client's impairment.

Physician/Psychologist's signature:	Is VAC to be invoiced? ◯ Yes ◯ No	Telephone No. ( )	Today's date:

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Activities of Daily Living (ADL) Questionnaire

Family name:	Given name:	Date of Birth:
Name of Physician:		Date of Examination:

IF APPLICABLE TO THE CLAIMED/PENSIONED CONDITION(S), PLEASE COMPLETE THIS SHEET

Activities of Daily Living:

Please describe the impact that the <u>pensioned conditions</u> have on Activities of Daily Living.

Select the description that <u>most accurately</u> reflects the client's current level of functioning for each of the following activities:

Activity	Independent	Independent (with aids)	Requires reminders, prompting and/or supervision in addition to minor assistance	Needs extensive assistance	Totally dependent
Eating	◯	◯	◯	◯	◯
Bathing	◯	◯	◯	◯	◯
Grooming	◯	◯	◯	◯	◯
Dressing	◯	◯	◯	◯	◯
Toiletting	◯	◯	◯	◯	◯
Transferring	◯	◯	◯	◯	◯

Please elaborate (list aids required, ability to sit/stand unaided during task, safety concerns, bed mobility, etc.):

Continence/Incontinence:

Select the description that <u>most accurately</u> reflects the client's current level of bladder and bowel control:

	Continent (No assistance needed)	Occassional nighttime incontinence (once a week or less)	Daytime incontinence (more than once per week)	Daytime (daily) incontinence (requiring protective padding)	Daytime (daily) incontinence (requiring intervention by others)	Total incontinence
Bladder	◯	◯	◯	◯	◯	◯
Bowel	◯	◯	◯	◯	◯	◯

Comment: Please note the number of incontinence pads used/day, if applicable.

Locomotion: Please comment on any difficulty with walking, provide walking distance, and list aids required.

Chronic Pain: Please comment on pain intensity, frequency, symptoms and response to treatment.

Comments: Please remember to note other contributing conditions.

Physician's signature:	Today's date:

Family name:	Given name:	File No.:

Additional Comments:

Physician/Psychologist's signature:	Today's date: