BRUCE W. EBERT, PH.D., J.D., LL.M.
Attorney at Law
3400 Douglas Blvd., Suite 250
Roseville, CA 95661
(916) 781-7875; (916) 781-2632 fax

VETERANS INTAKE FORM

Name: ________________________________ Date: ________________________

Address: ____________________________City/State/Zip: ______________________

Email Address: ____

Home Phone:__________________ Work Phone: _________________ SSN: ____________

Cell Phone:__________________ Fax:_________________ Other: __________________

Occupation: __________________

Business Name/Employer:____

Business Address: ____

If Dr. Ebert or staff calls, how do you want to be identified and how would you like Dr. Ebert to identify himself if someone other than you answers the phone? ___________________________

____

Drivers License No:________________________ State:________ Expiration:____________

Martial Status:______Length of Marriage:______ D.O.B.______________ Age: ________

Race/Ethnicity:_______________(Optional) Gender: M F (circle one)

Spouse:_______________________________ Employer: __________________________

Auto/Homeowner Insurance Co.:_________________________ Policy/Group #:___________

Contact Person/Agency:___________________________ Phone: _______________________

Address: ____

Does your policy provide “Legal Defense attorney’s fees and costs” coverage? Y N

PRIOR MILITARY SERVICE

Branch of Service: ___________________________________

Dates of Service: ____________________________________

Precise Date of Discharge: ____________________________

Duty Title/Titles (MOS): _____________________________

Highest Rank Achieved? _____________________________

Any Article 15s? If Yes, Please Describe: ____
____
____

Ever Face a Court-Martial? If Yes, Please Describe: _______________________________________
____
____
____

Characterization of Discharge: (i.e. honorable, BCD, DD, General) : ________________________

TDY on Foreign Soil? If Yes, Please Describe: ____
____
____
____
____
____

Combat Veteran? Y N

If Yes please describe your activities: ____
____
____
____
____

Any Injuries During Service? Please Describe: ____
____
____
____

Any Illnesses During Service? Please Describe:

Have You Ever Been Exposed to Asphestos over a Long Period of Time? Y N

Please Describe:

Did You Ever Undergo a Surgical Procedure During Service? Please Describe:

Did You Ever have a Blood Transfusion While on Active Duty? Please Describe:

Do you have your Military Records? Y N

Do you have your Military Medical Records? Y N

Have You Ever Received a Medical Retirement or Placed on TDRL Associated with Your Service? Please Describe:

VETERANS ADMINISTRATION INFORMATION

Have You Filed a Claim with the VA? Y N

If so, When? ____

Have You Filed Multiple Claims with the VA? Y N

If so, Please Describe: ____

____

Have You Ever Received a Denial from the VA? Y N

If so, Please Describe: ____

____

____

If You Received a Denial Exactly What was the Date of the Denial? ____________________

Have You Ever Received a Statement of the Case from the VA? Y N

Have You Ever Been Represented by Another Attorney before the VA? Y N

Have You Ever Been Represented by a Veteran Service Officer? Y N

If Yes, Please Provide the Name and Circumstances: ______________________________

____

____

____

____

____

LEGAL INFORMATION

Prior Attorney: Y N If so, name: ______________________________

Prior Attorney's Address: ____

Reason for Representation: ____

____

Currently involved in litigation: Y N

If so, please describe litigation type: ___________________________________

____

Next Court Date:__________________County of litigation: _____________________

Professional Licenses:

Psychology________Physician_______ MFT______ Nurse _______

LCSW________ LEP_________ Teacher _______

License No:___________________ License Issued:___________ State: ______

Professional Practice Insurance Co.:_____________________Policy/Group #:__________

Contact Person/Agency:________________________ Phone: ____________________

Address: ____

Does your policy provide "Legal Defense attorney's fees and costs" coverage? Y N

EDUCATION:

Highest Grade Completed:_______ College GPA:______ High School GPA:_______

Disability Income? Y N

If Yes: SSI_______ Private_______ VA________ Other_______

Reason for Disability Payments:_______________________________________

Learning Disabilities (please describe)_______________________________________

____

Learning Disabilities in: Math Science Reading English Spelling

Have you ever required:

Speech Therapy Y N Physical Therapy Y N

Dyslexia Y N (ADHD) Attention Deficit Hyperactivity Disorder Y N

Do you believe you currently suffer from ADHA? Y N

Insurance Company:________________________________ Policy No:_______________

Address:____ Insured:_________________

MEDICAL INFORMATION

Medical Doctor:____________________ Physician's Phone No.: _____________

Address:____

Date of Last Physical Exam:_________________ Reason:______________________________

Physical Problems/
Symptoms:____

____

____

____

PHYSICAL SYMPTOMS

Symptom			Symptom		
1. Headaches	Y	N	9. Chronic Cough	Y	N
2. Blurring Vision	Y	N	10. Balance Problems	Y	N

3. Hearing Loss	Y N		11. Muscle Weakness	Y	N
4. Chronic Pain	Y N		12. Numbness	Y	N
5. Neck Pain	Y N		* Where?		
6. Chest Pain	Y N		13. Palpitation	Y	N
7. Stomach Pain	Y N		14. Ringing in Ears	Y	N
8. Facial Pain	Y N		15. Sleep Apnea	Y	N

If you suffer from any type of pain, please rate your pain right now on a scale of 1-10 with 10 being the worst pain and 1 being the lowest:_______________________________________

Previous Counseling? Y N With Whom and When:______________________

Mediation Currently Taking (Please list every medication you have taken in the past year):

Medication	Dosage	First Taken	Reason for Medication	Discontinued
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				
9.				
10.				

SURGERIES

Type of Procedure	Date	Hospital	Doctor	Complication
1.				
2.				
3.				
4.				
5.				
6.				
7.				
8.				

MEDICAL PROCEDURES

(Check all that apply)

MRI_______ CT SCAN_______ PET SCAN______ EEG______

X-RAYS______ SPECT SCAN______EVOKED POTENTIAL______

SLEEP STUDY_______ BLOOD TEST______ UA______

COLONOSCOPY______ ENDOSCOPY______ BODY SCAN______

ULTRASOUND______ ECHOCARDIAGRAM______ TREADMILL______

MEDICAL HISTORY

Heart Disease______ Hypertension______ Hypotension______ Enlarges Heart_______

Mitral Valve Problem_______ Arrhythmia______ Chronic Pain______ Chronic Fatigue______

Joint Pain______ Chronic Fear______ Chronic Fatigue____ Fibromyalgia______

Syndrome

Asthma______	Restless Leg_____	COPD______	Lung Cancer______
Multiple______ Sclerosis	Lupus______	Parkinson's______	Kleinfelter_______ Syndrome
Jacob______ Syndrome	Diabetes______	Hepatitis______	Epilepsy______
Thyroid______ Disease	Cancer______	Sleep Apnea______	Kidney______ Problems

Please list your blood pressure the last time you had it taken:_____________________

If Known: Normal Heart Rate:________ Blood Sugar Level:_____________

Height:_________ Weight:__________

Describe any weight loss with in the past six months:_______________________________

Cholesterol:______________________ Triglycerides:_____________________

LDL: _____________ HDL: _____________

Blood Sugar Level: ______________ Hemoglobin A1C: _____________

ALCOHOL HISTORY

Do you drink alcohol? Y N Drinks per week? _______________

When you drink, what type of alcoholic beverages do you consume (circle all that apply)?

Beer	Wine	Wine Cooler	Whiskey	Tequila
Rum	Rum 151	Vodka	Brandy	Gin

Other ___________________

Have you ever had a blackout while under the influence of alcohol? Y N

If yes: How many? ________ Last time it happened? ___________

Ever do anything you deeply regretted in a blackout? Y N

Ever have problems with the law in a blackout? Y N

Ever had a blackout without drinking alcohol? Y N

Have you ever been diagnosed as suffering from alcoholism? Y N

Has anyone in your family been diagnosed as being an alcoholic? Y N

If so, please tell us the person's relationship to you: ________________________.

Has anyone in your life ever told you that you have a drinking problem? Y N

DRUG USE (INFO IS PROTECTED BY ATTORNEY-CLIENT PRIVILEGE)

It is critically important that you list any and all drugs you have used in the past three years. Drugs may have an effect on behavior, mood, feelings, thoughts and interactions with others. They are relevant to medical and psychological treatment. So please be very honest in circling each and every drug you have used.

Marijuana Hashish Methamphetamines (Crank) Cocaine

Rock Cocaine Amphetamines (Speed) Dexadrine LSD Mescaline

Peyote Psylocybin Hallucinogenic Mushrooms SHERM PCP

STP MDA Rohypnol Heroin Barbiturates

Methyqualludes Ecstacy Ketamine GHB Coricidin (to get high)

INHALANTS: Nitrous Oxide Glue Gas Paint Other:____________

Prescription Narcotics Illegally: Vicodin Tylenol#3 w/ Codeine OxyContin

Percocet/Percodan Morphine Fentanyl Norco Ultram

Other Prescription Drugs Illegally: Ritalin Concerta Dexadrine

Have you ever used an illicit drug intravenously? Y N

Have you ever been a patient in a drug treatment program? Y N

If so, please tell us when: ___________________________________

CONCLUSION

Please Be Advised That VA Cases Take a Very Long Time, Often Years. If You are Seeking Help from Dr. Ebert it Means Your Case is Complicated. Complex Cases Take a Very Long Time. Your Signature Below Indicates You Fully Understand This.

______________________________________ ___________________

Signature of Client Date

Notify in case of emergency:

Name:_______________________________________ Phone: _____________________________

Address:____

Relationship to you: ____

REASON FOR SEEKING LEGAL SERVICES AT THIS TIME: __________________________

____

____

____

May we ask who referred you to this office? ____

COLLATERAL CONTACTS

In an evaluation or legal case, there is often the need to contact other people who may have important information relevant to the case. These are called collateral contacts. Please list the most relevant individuals for Dr. Ebert to contact if he decides to.

NAME	ADDRESS	TELEPHONE/FAX	RELATIONSHIP

LEGAL HISTORY

NAME OF LITIGATION	DATE OF FILING	VENUE	OUTCOME/DATE RESOLVED

CONCLUSION

What would you like to accomplish with the assistance of Dr. Ebert? ______________________

____

____

____

When do you think this matter will come to its conclusion? ______________________________

____

____

____