Traumatic Brain Injury (TBI)
Signs and Symptons Questionnaire

Service No.: _____ SSN: _____

End of obligated active service: _____

Where and when did you file your first claim : _____

Was any portion of your claim denied? YES ☐ NO ☐ Was the decision appealed? YES ☐ NO ☐

What was the reason for the denial? _____

What type of blast(s) were you exposed to? Circle all that apply. ☐ Grenades ☐ IED ☐ Mortar Rounds
☐ Other:_____

Were you exposed to multiple blasts? YES ☐ NO ☐ (In feet) approximately how close were you to the actual blast(s)?_____

State the date(s) and location(s) (region) of blast(s): _____

Did you receive any shrapnel wounds? YES ☐ NO ☐

Location on body of wounds: _____

Check Any of the Following Symptoms That Have Occured From the Date of Exposure to the Blast.
(Double Check if Medical Documentation is of Record):

		Medical Documentation			Medical Documentation
Loss of Spinal Fluid From Ears or Nose	☐	☐	Weakness/Poor Coordination	☐	☐
Loss of Consciousness	☐	☐	Paralysis/Difficulty Moving Body Parts	☐	☐
Seizures	☐	☐	Dizziness/Balance Problems	☐	☐
Behavioral Changes	☐	☐	Numbness and Tingling	☐	☐
Mood Changes	☐	☐	Headaches	☐	☐
Irritability/Depression/Anxiety	☐	☐	Confusion/Memory Problems/Difficulty Thinking	☐	☐
Difficulty speaking/Slurred Speech	☐	☐	Loss in Problem Solving Abilities	☐	☐
Fatigue	☐	☐	Nausea	☐	☐
Loss of Bladder Control	☐	☐	Bad Taste in the Mouth	☐	☐
Blindness	☐	☐	Blurred Vision	☐	☐
Dilated or Unequal Pupils	☐	☐	Loss of Eye Movement	☐	☐
Hearing Changes	☐	☐	Sensitivity to Light or Noise	☐	☐
Insomnia	☐	☐	Ringing in the Ears	☐	☐
Change in Sleep Patterns	☐	☐			

Have your Disabilites Stabilized ☐ YES ☐ NO

Are you about to be discharged from active duty and are your disabilities still unhealed or incompletely healed? ☐ YES ☐ NO

Date: _____

_____ (Signature of Veteran)

_____ (Printed Name)

Reset Form

Print Form

OMB Approved No. 2900-0075
Respondent Burden: 15 minutes

Department of Veterans Affairs

STATEMENT IN SUPPORT OF CLAIM

PRIVACY ACT INFORMATION: The VA will not disclose information collected on this form to any source other than what has been authorized under the Privacy Act of 1974 or Title 38, Code of Federal Regulations 1.576 for routine uses (i.e., civil or criminal law enforcement, congressional communications, epidemiological or research studies, the collection of money owed to the United States, litigation in which the United States is a party or has an interest, the administration of VA Programs and delivery of VA benefits, verification of identity and status, and personnel administration) as identified in the VA system of records, 58VA21/22, Compensation, Pension, Education and Rehabilitation Records - VA, published in the Federal Register. Your obligation to respond is required to obtain or retain benefits. VA uses your SSN to identify your claim file. Providing your SSN will help ensure that your records are properly associated with your claim file. Giving us your SSN account information is voluntary. Refusal to provide your SSN by itself will not result in the denial of benefits. The VA will not deny an individual benefits for refusing to provide his or her SSN unless the disclosure of the SSN is required by Federal Statute of law in effect prior to January 1, 1975, and still in effect. The requested information is considered relevant and necessary to determine maximum benefits under the law. The responses you submit are considered confidential (38 U.S.C. 5701). Information submitted is subject to verification through computer matching programs with other agencies.

RESPONDENT BURDEN: We need this information to obtain evidence in support of your claim for benefits (38 U.S.C. 501(a) and (b)). Title 38, United States Code, allows us to ask for this information. We estimate that you will need an average of 15 minutes to review the instructions, find the information, and complete this form. VA cannot conduct or sponsor a collection of information unless a valid OMB control number is displayed. You are not required to respond to a collection of information if this number is not displayed. Valid OMB control numbers can be located on the OMB Internet Page at www.whitehouse.gov/omb/library/OMBINV.html#VA. If desired, you can call 1-800-827-1000 to get information on where to send comments or suggestions about this form.

FIRST NAME - MIDDLE NAME - LAST NAME OF VETERAN *(Type or print)*	SOCIAL SECURITY NO.	VA FILE NO. C/CSS -

The following statement is made in connection with a claim for benefits in the case of the above-named veteran:

This is statements in support of Traumatic Brain Injury Questionaire dated : _____

I CERTIFY THAT the statements on this form are true and correct to the best of my knowledge and belief.

SIGNATURE	DATE SIGNED	
ADDRESS	TELEPHONE NUMBERS *(Include Area Code)*	
	DAYTIME	EVENING

PENALTY: The law provides severe penalties which include fine or imprisonment, or both, for the willful submission of any statement or evidence of a material fact, knowing it to be false.

CONTINUE ON REVERSE

Reset Form

Print Form

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