The Saroyan Law Firm, L.L.C.

Veterans' Disability Case Evaluation

Name _____

Address _____

Phone _____

Email _____

Age _____ Birth date _____ SSN _____

Male/Female Dependents: _____

Marital Status: _____ Education: _____

Are you currently employed? Last date worked _____

Branch of the service: _____

Dates served: _____

Did you receive a Military Medical Board Rating? Yes / No If so, what rating ____%

Have you filed a claim with the VA? _____ Date you filed claim? _____

Type of benefits you applied for? ___ Disability Compensation; ____Benefits for Dependents;
___ Pension; ____ Death benefits (Your relationship to the deceased _____)

Have you received a Rating Decision? If yes, please state for what and each rating:

_____

_____

_____

Overall rating _____ %

Have you received a Statement of the Case? ___ Yes ___ No

Have you filed a Notice of Disagreement? _____ Date NOD filed? _____

Have you requested a hearing (filed a VA Form 9)? ___ Yes ___ No

If so, date filed? _____

Has your case gone to the U.S. Court of Appeals for Veterans Claims (CAVC) _____

Have any of your doctors told you not to work? _____

Have any of your doctors given you work restrictions, if yes, please give doctor's name and any restrictions given:

_____
_____

Please list the medications you take for your disabling conditions:

_____
_____
_____

Please list the doctors who treat you for your disabling conditions:

_____
_____
_____

How often do you see a doctor? _____

Please list any surgeries you have had related to your disabilities:

_____
_____

Is there any drug abuse in your history? _____ If yes, drug abused? _____

Treatment received? _____

Time of being free from drug use? _____

Is there any alcohol abuse in your history? _____ Time sober? _____

Treatment received? _____