



## VETERANS FREEDOM RETREAT APPLICATION

### PERSONAL INFORMATION

All personal information is confidential and treated accordingly.

Service Member/Veteran Name\* \_\_\_\_\_ DOB\* \_\_\_\_\_

Last 4 digits of SSN\* \_\_\_\_\_ Ethnicity \_\_\_\_\_ Tribal Affiliation \_\_\_\_\_

Primary Language: \_\_\_\_\_ Secondary Language: \_\_\_\_\_

Name of Spouse/Partner\* \_\_\_\_\_ DOB\* \_\_\_\_\_

Last 4 digits of SSN\* \_\_\_\_\_ Ethnicity \_\_\_\_\_ Tribal Affiliation \_\_\_\_\_

Primary Language: \_\_\_\_\_ Secondary Language: \_\_\_\_\_

Relationship to Veteran if not spouse\* \_\_\_\_\_

Veteran Home Address\* \_\_\_\_\_

City\* \_\_\_\_\_ State\* \_\_\_\_\_ Zip Code\* \_\_\_\_\_

Number of Children \_\_\_\_\_ Ages/Gender \_\_\_\_\_

Home Phone\* \_\_\_\_\_ Vet Cell\* \_\_\_\_\_ Partner Cell:\* \_\_\_\_\_

Vet Email\* \_\_\_\_\_ Partner Email\* \_\_\_\_\_

### SERVICE INFORMATION

Branch of Service\* \_\_\_\_\_ Service Years\* \_\_\_\_\_ Discharge Date\* \_\_\_\_\_

Combat Zone(s) \_\_\_\_\_ Deployment Dates \_\_\_\_\_

Units/MOS/AFSC \_\_\_\_\_

Awards/Decorations \_\_\_\_\_

Current Status:\*  Active Duty  Military Retired  Veteran  Other: \_\_\_\_\_

Is your Spouse/Partner a military veteran?\* Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please provide the following:\*

Branch of Service\* \_\_\_\_\_ Service Years\* \_\_\_\_\_ Discharge Date\* \_\_\_\_\_

Combat Zone(s) \_\_\_\_\_ Deployment Dates \_\_\_\_\_

Units/MOS/AFSC \_\_\_\_\_

Awards/Decorations \_\_\_\_\_

Current Status:  Active Duty  Military Retired  Veteran  Other: \_\_\_\_\_

\* Required information.



## POST TRAUMATIC STRESS (PTS) INFORMATION

**The Veteran must have been diagnosed with a type of PTS or Referral by Chaplain or Counselor.**

Veterans PTS was diagnosed: Date/Year\* \_\_\_\_\_  VA or Other Facility?\* \_\_\_\_\_

Professional Health Care Provider Diagnoses?\* - Bipolar Disorder - PTSD - Anxiety Disorders - TBI  
- Eating Disorders - Substance Disorders - Schizophrenia - Personality Disorders - MST

Current/Past Counseling:\*

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Has your Spouse/Partner been diagnosed with PTS? Yes \_\_\_\_\_ No \_\_\_\_\_ If so, please have them answer the following questions and complete the PTS questionnaire beginning on page 4:

PTS was diagnosed: Date/Year \_\_\_\_\_  VA or Other Facility? \_\_\_\_\_

Professional Health Care Provider Diagnoses?\* - Bipolar Disorder - PTSD - Anxiety Disorders - TBI  
- Eating Disorders - Substance Disorders - Schizophrenia - Personality Disorders - MST

Current/Past Counseling:\*

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## VETERAN PTS SYMPTOM QUESTIONNAIRE

Veteran Participant's Name\* \_\_\_\_\_ Date\* \_\_\_\_\_

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then circle/check one of the numbers to the right to indicate how much you have been bothered by that problem in the past month. Make sure to base your answer on problems that started or got worse after the event. The event you experienced was (Name event) \_\_\_\_\_

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in \_\_\_\_\_ (month/year when event occurred). Indicate how much you were bothered by each item in the last month. As a guide: Extremely might mean almost every day; Quite a Bit might mean 20 days out of the past 30 days; Moderately might mean ten to 14 days; and A Little Bit might mean any number of days less than ten days out of the last 30. If you were not bothered by the indicated problem at all during the last 30 days, select Not At All.

\* Required Information.

**VETERAN PTS SYMPTOM QUESTIONNAIRE (Continued) \***

**Veteran Participant's ID # \_\_\_\_\_ (1<sup>st</sup> & Last Initials + Last 4)**

	<b>Response</b>	<b>Not At All</b>	<b>A Little Bit</b>	<b>Moderately</b>	<b>Quite A Bit</b>	<b>Extremely</b>
1	Repeated, disturbing, and unwanted memories of the stressful experience?					
2	Repeated, disturbing dreams of the stressful experience?					
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?					
4	Feeling very upset when something reminded you of the stressful experience?					
5	Having strong physical reactions when something reminded you of the stressful experience (for example, heart pounding, trouble breathing, sweating)?					
6	Avoiding memories, thoughts, or feelings related to the stressful experience?					
7	Avoiding external reminders of the stressful experience (for example, people, places, conversations, activities, objects, or situations)?					
8	Trouble remembering important parts of the stressful experience (for some reason besides a head injury or alcohol or drug use)?					
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?					
10	Blaming yourself or someone else (who didn't directly cause the event or actually harm you) for the stressful experience or what happened after it?					
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?					
12	Loss of interest in activities that you used to enjoy?					
13	Feeling distant or cut off from other people?					
14	Having trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?					
15	Feeling irritable or angry or acting aggressively?					
16	Taking too many risks or doing things that could cause you harm?					
17	Being "super alert" or watchful or on guard?					
18	Feeling jumpy or easily startled?					
19	Having difficulty concentrating?					
20	Trouble falling or staying asleep?					

\* Required Information



## PARTNER / SUPPORT PERSON PTS SYMPTOM QUESTIONNAIRE

Partner / Support Person Name\* \_\_\_\_\_ Date\* \_\_\_\_\_

The purpose in having you to join your veteran is not only for you to help provide support and healing to them, but also to provide a healing opportunity for you. Our focus throughout the retreat will be to meet the needs of both you and your partner equally.

To help us do this, we would like to understand the degree to which you might be experiencing symptoms of stress in your life whether the symptoms result from your own history of trauma, the normal stresses of life or from your relationship with someone who has PTS. Please answer the two questions below, and complete the attached PTS questionnaire.

Where the questionnaire uses the term “the stressful experience”, you may answer according to a specific experience you have had or to the overall stress you experience in your life.

Before you complete the questionnaire, please answer the following questions:

1. On average, to what degree do you experience normal stress/distress? 0-10 (0 = none; 10 = extreme) \_\_\_\_\_
2. Have you had an experience(s) where you felt your ethics (your sense of right and wrong) was strongly violated, resulting in a significant sense of self-blame, shame, confusion, anger/rage or depression? \_\_\_\_\_

Instructions: Below is a list of problems and complaints that people sometimes have in response to stressful life experiences. Please read each one carefully, and then circle/check one of the numbers to the right to indicate how much you have been bothered by that problem in the past month. Make sure to base your answer on problems that started or got worse after the event. The event you experienced was **(Name event)** \_\_\_\_\_

**in** \_\_\_\_\_ **(month/year when event occurred)**. Indicate how much you were bothered by each item in the last month. As a guide: Extremely might mean almost every day; Quite a Bit might mean 20 days out of the past 30; Moderately might mean ten to 14 days; and A Little Bit might mean any number of days less than ten days out of the last 30 days. If you were not bothered by the indicated problem at all during the last 30 days, select Not at All.

\* Required Information

**Partner / SUPPORT PERSON PTS SYMPTOM QUESTIONNAIRE (Continued) \***

**Partner/Support Person ID # \_\_\_\_\_ (1<sup>st</sup> & Last Initials + Last 4)**

	<b>Response</b>	<b>Not At All</b>	<b>A Little Bit</b>	<b>Moderately</b>	<b>Quite A Bit</b>	<b>Extremely</b>
1	Repeated, disturbing, and unwanted memories of the stressful experience?					
2	Repeated, disturbing dreams of the stressful experience?					
3	Suddenly feeling or acting as if the stressful experience were actually happening again (as if you were actually back there reliving it)?					
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8	Trouble remembering important parts of the stressful experience (for some reason besides a head injury or alcohol or drug use)?					
9	Having strong negative beliefs about yourself, other people, or the world (for example, having thoughts such as: I am bad, there is something seriously wrong with me, no one can be trusted, the world is completely dangerous)?					
10	Blaming yourself or someone else (who didn't directly cause the event or actually harm you) for the stressful experience or what happened after it?					
11	Having strong negative feelings such as fear, horror, anger, guilt, or shame?					
12	Loss of interest in activities that you used to enjoy?					
13	Feeling distant or cut off from other people?					
14	Having trouble experiencing positive feelings (for example, being unable to feel happiness or have loving feelings for people close to you)?					
15	Feeling irritable or angry or acting aggressively?					
16	Taking too many risks or doing things that could cause you harm?					
17	Being "super alert" or watchful or on guard?					
18	Feeling jumpy or easily startled?					
19	Having difficulty concentrating?					
20	Trouble falling or staying asleep?					

\*Required Information



## MEDICAL INFORMATION

### Veteran

\* Service connected disability: % \_\_\_\_\_ Condition/Basis \_\_\_\_\_

\* Prescription Medications: \_\_\_\_\_  
\_\_\_\_\_

\* Non-prescribed / illegal drug / alcohol use. What substance and how much / how often? \_\_\_\_\_  
\_\_\_\_\_

\* If you are in recovery, how long? \_\_\_\_\_

**NOTE: Bring at least an 8 day supply of your prescription medications.**

**VETERAN'S Physical Conditions** that require assistance/unique accommodations:

Motorized Wheelchair  Wheelchair  Walker  Cane  Other: \_\_\_\_\_

\* Medical Conditions:  Diabetic  Oxygen  Nebulizer  CPAC or other similar equipment

Other Medical Conditions: \_\_\_\_\_

Sensitivities or Allergies:  Smoke  Other: \_\_\_\_\_

Dietary:  Vegetarian  Vegan  Gluten Free  Other: \_\_\_\_\_

We will do our best to accommodate your dietary needs, but please come prepared if you require anything special. There will be a small refrigerator in each room.

Service Animal: Purpose \_\_\_\_\_ Certified: Yes  No  Breed: \_\_\_\_\_

(Please bring a kennel for your pet(s) if you leave them in your cabin while in class)

### **\*\*\*Fraudulent Representation\*\*\***

*A person who uses an assistance animal with a harness or leash of the type commonly used by persons with disabilities to represent that his or her animal is a specially trained service animal when not trained as such, is guilty of a misdemeanor. Punishable by a fine of not more than \$300 and 30 hours of community service.*

T. C. A., Human Resources Code § 121.006

\* **Required information.**



## MEDICAL INFORMATION

### PARTNER / SUPPORT PERSON

\* Service connected disability: % \_\_\_\_\_ Condition/Basis \_\_\_\_\_

\* Prescription Medications: \_\_\_\_\_

\* Unprescribed / illegal drug / alcohol use. What substance and how much / how often? \_\_\_\_\_

\* If you are in recovery, how long? \_\_\_\_\_

NOTE: Bring at least an 8 day supply of prescription medications.

PARTNER / SUPPORT PERSON'S Physical Conditions that require assistance/unique accommodations:

Motorized Wheelchair  Wheelchair  Walker  Cane  Other: \_\_\_\_\_

\* Medical Conditions:  Diabetic  Oxygen  Nebulizer  CPAC or other similar equipment

Other Medical Conditions: \_\_\_\_\_

Sensitivities or Allergies:  Smoke  Other: \_\_\_\_\_

Dietary:  Vegetarian  Vegan  Gluten Free  Other: \_\_\_\_\_

We will do our best to accommodate your dietary needs, but please come prepared if you require anything special. There will be a small refrigerator in each room.

Service Animal: Purpose \_\_\_\_\_ Certified: Yes  No  Breed: \_\_\_\_\_

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T. C. A., Human Resources Code § 121.006

\* Required information.



## OTHER INFORMATION

What first name would you like on your name-tag? VETERAN \_\_\_\_\_ PARTNER \_\_\_\_\_

We conduct Equine Therapy on one day of the retreat followed by a very mellow horse “whisperer” session of trying to get a horse to join-up with different Participants to show the importance of allowing the horse to accept you instead of being forced to do what you want them to do. If you want to participate in the joining process, please mark “Horse Whisper.”

Veteran - Horse Whisper? (Yes or No) \_\_\_\_\_ Partner - Horse Whisper? (Yes or No) \_\_\_\_\_

## RETREAT INFORMATION

Participants should arrive at the retreat location between the hours of 1:00 PM and 3:00 PM. Travel will be paid by the participant. The Retreat does not cover any travel expenses. Lodging and meals will be provided at no cost to the participants. Due to the discussions and nature of these retreats, children under 18 are not allowed to attend.

Comfortable, casual attire such as jeans, shorts, tennis shoes, bathing suits, hats and sunscreen are recommended. Closed toed shoes are necessary for equine therapy. Some activities will require exercise or loose clothing. Cool evening temperatures are expected and sweaters and light jackets are appropriate. Participants should bring pants or ankle length skirts for Native American ceremonies. We also have an evening dinner with dancing, please bring appropriate clothing.

**IF YOU ARE A SINGLE VETERAN WHO HAS NO PARTNER**, but would be willing to partner with another vet who has completed the retreat and can mentor you during and after your retreat, please indicate below.

- Yes, I would like another Veteran to be my PTS support person during and after the retreat.
- No, I do not want a Veteran support person during and after the retreat. I will continue to seek a partner before my retreat.

For questions relative to the Retreat Application process or dates, please call (940) 867-1863 or (940) 867-3987.

Once your application has been received and processed, you will be notified and placed in one of our first available scheduled retreats. See webpage ([vfr.vet](http://vfr.vet)) for additional retreat testimonials and information. If circumstances require a particular retreat start date, please indicate below. Availability may be limited.

1<sup>st</sup> Choice \_\_\_\_\_ 2<sup>nd</sup> Choice: \_\_\_\_\_

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Mail the entire completed Retreat Application, with Registration Fee (Check/Money Order) and a copy of your Form DD-214 to:

Veterans Freedom Retreat  
7200 Robertson Road  
Fort Worth, Texas 76135

OR, Email scanned applications & DD-214s to [DJones@VFR.vet](mailto:DJones@VFR.vet)

**NO FAX NUMBER!**

**\* All attendees must commit to the FULL seven and a half days of the Retreat. \***

\_\_\_\_\_ I agree and understand that neither firearms nor illegal substances are allowed on the premises of the retreat, including in vehicles, nor to be consumed at any time during the retreat. (Please Initial)

\_\_\_\_\_ I understand that due to the numerous last minute cancellations and No-Shows of previous VFR Registrants, we are asked for a **\$50 Registration Fee** (make check/Money Order out to **Veterans Freedom Retreat**), to be refunded upon completion of the VFR Retreat. (Please Initial)

**We will be sending out e-mails with updates and queries several times before the VFR Retreat begins. Please respond to the e-mails, failure to respond and confirm your attendance by two weeks prior to the retreat will be reason to fill your position with others on the waiting list.**

I/We have read the above and believe all of the answers given on the Retreat Application are true and correct.

\_\_\_\_\_  
Signature of Service Member/Veteran\* Date \*

\_\_\_\_\_  
Signature of Spouse/Partner\* Date \*

**How did you hear about the Veterans Freedom Retreat?** \_\_\_\_\_

**\* Required information.**