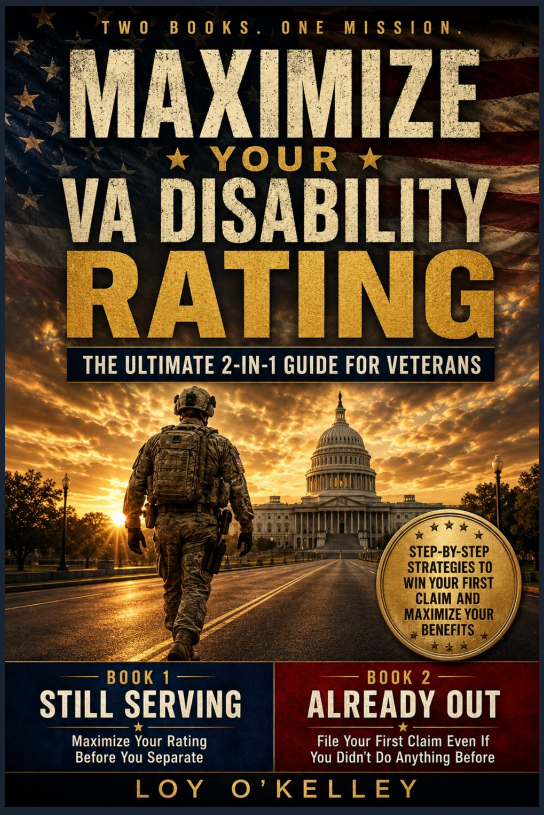
FREE SAMPLE



Maximize Your VA Rating

The 2-in-1 guide for service members and veterans

IN THIS SAMPLE

Chapter 6: The Head-to-Toe Checklist
Chapter 20: C&P Exam Mistakes and Red Flags

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Chapter 6: Don't Forget Anything (Head-to-Toe Checklist)

Here's a pattern I've seen in packet after packet: the veteran claims the big, obvious conditions — the blown knee, the bad back — and completely forgets four or five others that were just as real and just as ratable. The tinnitus he's had so long he thinks silence sounds like ringing. The heartburn he eats antacids for daily. The scar tissue. The numb patch on his thigh. The sleep that hasn't been right since his second deployment.

Nobody forgets their worst condition. What veterans forget — constantly — is everything their body has *normalized*. After enough years, pain becomes background noise. You stop noticing what you live with. And a condition you don't notice is a condition you never document, never claim, and never get rated for.

This chapter is the counter-drill: a deliberate, top-down inventory of your entire body and mind. Then it covers the one exam where that inventory matters most — your separation physical.

The Inventory Drill

Set aside a quiet hour. Take the checklist below and go through it slowly, top of the skull to the soles of your feet. For every system, ask yourself three questions:

1. **Do I have any symptom here — even one I consider minor or "normal for me"?**

2. **Did it start or get worse during service?**
3. **Is it documented anywhere in my medical record?**

Anything that scores yes-yes-no goes on your action list for sick call, per the doctrine in Chapter 5. And write it all down — this inventory becomes your master condition list, the document that drives your entire claim in Part V.

One tool sharpens this drill more than any other: **ask the people who live with you.** Your spouse knows you stop breathing at night. Your kids know you can't sit through a movie without standing to stretch your back. Your battle buddy knows you say "what?" three times a conversation. You've normalized your symptoms; they haven't.

> **PRO TIP:** Do this drill twice. Once alone, once with your spouse or someone who knows you well. The second pass almost always finds things the first one missed — usually sleep, hearing, and mood, the three things you're least able to observe in yourself.

The Head-to-Toe Checklist

- ☐ **Head:** Headaches or migraines? How often, and do they put you down for the count? Any history of head impacts, blasts, or concussions — even ones you shook off?
- ☐ **Ears:** Ringing, buzzing, or humming (tinnitus)? Asking people to repeat themselves? TV volume creeping up? Years of weapons, aircraft, generators, or armor count as noise exposure whether or not you wore protection.
- ☐ **Eyes:** Vision changes, light sensitivity, injuries, or anything from blast exposure?
- ☐ **Sinuses and breathing:** Chronic congestion, sinus infections, trouble breathing through your nose? Shortness of breath, wheezing, coughing — especially if you lived next to burn pits, sandstorms, or industrial fumes?
- ☐ **Mouth and jaw:** Jaw clicking or pain (often a grinding/stress issue), dental trauma?
- ☐ **Mental health:** Sleep problems, nightmares, hypervigilance, irritability, anxiety, depression, intrusive memories, emotional numbness, alcohol creep? Be as honest here as anywhere on this list.
- ☐ **Neck:** Stiffness, limited motion, pain from years of helmets, night-

vision counterweights, vehicle jolts?

- ☐ **Shoulders:** Pain overhead, dislocations, separations, clicking, weakness — ruck straps and body armor live here.
- ☐ **Arms, elbows, wrists, hands:** Tendonitis, numbness or tingling in fingers, grip weakness, old fractures or sprains?
- ☐ **Chest and heart:** Palpitations, chest pain, known blood pressure creep? (Get your actual blood pressure history — "borderline" readings scattered through your record matter.)
- ☐ **Digestive:** Heartburn or reflux (how many antacids a week — count them), stomach pain, IBS-type symptoms, hemorrhoids?
- ☐ **Back:** Upper, mid, lower — pain, stiffness, spasms, limited motion? Does it shoot down a leg (that radiating pain is its own symptom — say so)?
- ☐ **Hips and pelvis:** Pain, popping, limited motion — often secondary to a lifetime of compensating for knees and back.
- ☐ **Groin and reproductive:** Hernias, injuries, dysfunction — including sexual dysfunction, which can be medication-related and is claimable. Uncomfortable to discuss; still real.
- ☐ **Knees:** Pain, instability, giving way, locking, swelling, grinding on stairs? Left and right are separate conditions — inventory each.
- ☐ **Ankles and feet:** Sprain history, chronic instability, plantar fasciitis, flat feet, numbness or cold-weather damage in the toes?
- ☐ **Skin:** Scars from wounds or surgeries (each one — location and size), rashes, eczema, fungal issues that flare, sun damage from years outdoors?
- ☐ **Nerves:** Numbness, tingling, burning, or "dead" patches anywhere — arms, hands, thighs, feet?
- ☐ **Sleep and energy:** Snoring, gasping awake, unrefreshing sleep, daytime exhaustion regardless of hours slept? (Ask your spouse. Then ask about a sleep study while it's free.)
- ☐ **Whole body and exposures:** Unexplained fatigue, joint pain that migrates, temperature intolerance? List every environmental exposure — burn pits, oil fires, chemicals, fuels, radiation sources, contaminated water — with locations and dates. Even without current symptoms, documented exposure matters, and Chapter 17 explains why.
- ☐ **Women's health:** Conditions related to service — MST-related conditions included — belong on this inventory like everything else. MST claims have special, more flexible evidence rules; Chapter 8 covers them.

Don't self-diagnose as you go — you don't need to know whether the knee thing is a meniscus or arthritis. Your job is to inventory *symptoms*; providers turn symptoms into diagnoses. And don't triage anything off the list as "too minor." A 0% or 10% rating still establishes service connection, still contributes to your combined rating, and still plants the flag for later if the condition worsens. Chapter 15 covers how to list conditions without either low-balling or kitchen-sinking.

> **REAL WORLD:** SSG Rivera's first solo pass produced four items: knees, back, tinnitus, sleep. Then he ran the drill again with his wife at the kitchen table. Her list for him: gasping awake at night, three antacid packets a week in his cargo pocket, the shrapnel scar he never mentions, saying "what?" constantly, and two years of white-knuckle irritability in crowds. His four-condition claim was actually nine or ten. Composite example — and the most common single upgrade I see when veterans run this drill with a spouse.

The Separation Physical: Your Last Word on the Record

Now for the event this entire inventory has been preparing you for: the **Separation History and Physical Examination (SHPE)** — your final military medical exam, completed in your last months of service.

Understand what this document is. For every condition you have, the SHPE is the military's closing statement about your health — the last in-service snapshot a VA rater will ever see. Evidence documented there sits at the exact hinge point between "in-service" and "current," which makes it disproportionately powerful for pillar two *and* pillar three of every condition on your list.

And understand how it goes wrong. After years of clearing medical hurdles by minimizing — because minimizing is how you stayed deployable, stayed on jump status, stayed off profile — you will sit down at your very last military exam with two decades of trained instinct screaming one phrase: *"I'm good, doc."*

At the SHPE, that instinct is sabotage. This is the one exam where under-reporting has no upside — there is no deployment to protect, no career to

guard, nothing left to stay eligible *for*. There is only your record, closing forever.

So the standing order for the SHPE is the exact opposite of every exam before it: **say everything.**

- Bring your written head-to-toe inventory and work it top to bottom. Do not do this from memory under time pressure.
- Report every symptom on the list — including, and especially, the ones already documented. "Still present" keeps a condition alive on paper; silence lets it die there.
- Give the four dimensions for each: frequency, duration, severity, functional impact.
- Include mental health, sleep, and exposures. All of it.
- Review what the examiner records before you sign, and speak up if something you reported didn't make it in.
- Get a complete copy of the SHPE for your own files before you clear.

> **WATCH OUT:** "Does anything bother you?" — "No, I'm good" at your separation physical can undercut two years of disciplined documentation. If a rater sees chronic back pain through your record and then "denies pain" at the final exam, you've handed the file an inconsistency at the worst possible moment. The SHPE is the last place on earth to be a tough guy.

One more time, because it's the drumbeat of this whole book: none of this is about inventing or inflating anything. Every item you report must be true. The drill exists because your problem isn't exaggeration — it's a decade of trained *under*-reporting. The inventory and the SHPE are where you finally correct the record to match reality. No more, no less.

Key Takeaways

- Veterans don't forget their worst conditions — they forget the normalized ones: tinnitus, reflux, scars, sleep, mood. A deliberate head-to-toe drill is the counter.
- Run the inventory twice, the second time with a spouse or someone who knows you — they see what you've stopped noticing.
- Inventory symptoms, not diagnoses, and keep "minor" items on the list — service connection now matters later, and even 0% plants the flag.

- Every yes-yes-no item (real symptom, service-related, undocumented) goes to sick call per Chapter 5. The inventory becomes your master condition list for Part V.
- The separation physical (SHPE) is your last word on the in-service record: bring the written list, say everything, verify the note, keep a copy. "I'm good, doc" is the most expensive sentence in this book.

Chapter 20: Common Mistakes & Red Flags

I've reviewed a lot of claims files, and here's a pattern that will break your heart: a veteran with two years of solid documentation, a clean evidence packet, statements from his squad — and a C&P exam report that torpedoes the whole thing because of what he said, or didn't say, in forty-five minutes.

The exam is where more good claims get underrated than anywhere else in the process. Not because examiners are out to get you, but because veterans keep making the same handful of unforced errors. Every mistake in this chapter is avoidable, and every one of them has a fix that costs you nothing but awareness.

Mistake 1: "I'm Fine" — The Minimizer

This is the big one, and it's practically encoded in our DNA. You spent years learning that the correct answer to "how are you doing?" is "good, sergeant." You drank water and drove on through injuries that would send a civilian to the emergency room. Now a stranger in a polo shirt asks how your back is, and twenty years of conditioning answers for you: "It's alright. I manage."

Congratulations — the DBQ now says you're alright and you manage.

The examiner cannot rate the pain you didn't mention. There is no checkbox for "veteran is clearly toughing it out." When you minimize, you're not being strong; you're giving false testimony against your own claim. The rating criteria don't measure your character. They measure your disability — and only the part of it you actually describe.

The fix: before you answer any "how bad is it" question, run it through one

filter — am I describing my actual life, or the version I'd give my platoon sergeant? Answer like the people who see you at home would answer. Better yet, ask your spouse before the exam: "What do I do when my back goes out?" You'll be surprised what they've watched you stop doing.

> **REAL WORLD:** SSG Rivera's first knee exam nearly went sideways this way. Examiner: "Does the knee affect your work?" Rivera, reflexively: "No, I get it done." What "getting it done" actually looked like: he'd quietly traded away every task involving ladders, took the elevator to avoid stairs, and iced his knee in his truck at lunch. His wife heard about the exam that night and made him write all of that down for his follow-up exam and his statement. "I get it done" and "I get it done by avoiding stairs, ladders, and kneeling, and icing at lunch" are the same fact — but only one of them can be rated.

Mistake 2: The Good-Day Performance

Related to minimizing, but sneakier. You feel decent on exam day, so you push. The examiner asks you to bend forward, and you grit your teeth and give maximum effort like it's a PT test, powering through pain without saying a word. The report reads: "Forward flexion to 85 degrees, no objective evidence of pain."

Here's what you need to know: under 38 CFR 4.59 and the DeLuca line of cases, where your pain starts matters, and your flare-ups matter. When an examiner measures your motion, say the word "there" the moment pain begins — not when you can't physically go further. Pain at 40 degrees is a different rating picture than pain at 85, even if you can force yourself to 85.

And if today is a good day, say so, out loud, and describe the bad ones with honest frequency — you learned the ethical framing for this in Chapter 19. An exam that only samples your best day is incomplete, and you're the only one in the room who knows it.

Mistake 3: Forgetting Flare-Ups and Work Impact

Two topics decide huge portions of most ratings, and veterans routinely leave both out unless asked directly:

- **Flare-ups.** How often, how long, how bad, what triggers them, and what you can't do during one. The DBQ has specific fields for this. If you don't volunteer it, some examiners won't dig for it, and the field gets marked "flare-ups not reported."
- **Work and daily life impact.** Occupational impairment is baked into the rating schedule — for mental health it's practically the whole scale. Missed days, accommodations, tasks you've offloaded, jobs you've turned down, the way you structure your day around the condition. Say it all.

Walk in with a mental (or written) list: my flare-ups, my work-arounds, my worst days, what I've given up. If the exam ends and something on that list never came up, raise it before you leave: "Doc, one more thing you should have for the form."

Mistake 4: Inconsistency With Your Records

Chapter 19 touched this from the examiner's side; here's the veteran's side. Your claims file already tells a story — sick call visits, your personal statement, buddy statements, treatment notes. The exam must be a chapter of the same book.

Inconsistency usually isn't lying. It's sloppiness. You told your doctor the migraines started "a few years ago" in 2022, wrote "since my 2019 deployment" in your statement, and tell the examiner "about ten years now." Three honest approximations, one credibility problem — because when details drift, the report can characterize your history as "inconsistent," and raters weigh credibility.

The fix: reread your own statements and symptom log the night before. Anchor your key dates and frequencies. You're not memorizing a script; you're making sure your honest testimony agrees with your honest paperwork.

> **WATCH OUT:** Inconsistency cuts both directions. Telling the examiner things are worse than you've ever told any treating provider raises flags — but so does casually telling the examiner "oh, I'm doing much better" when your treatment notes say otherwise, because exam-day nerves make lots of veterans chirpy and agreeable. Match your records. They're your story under oath.

Mistake 5: Exaggeration — The Red Flags Examiners Are Trained to Catch

Now the other end of the spectrum, and I'm going to be as direct as I was in Chapter 19: exaggeration is the one mistake that can't be fixed with a follow-up statement, because it doesn't just weaken your claim — it poisons your credibility on every claim you ever file.

Examiners — especially psychologists — are trained to recognize specific patterns. Know what they are, not so you can dance around them, but so you understand why honesty is also the winning strategy:

- **Over-endorsement.** Claiming every symptom on the list, all at maximum severity, all the time. Real conditions have shape and texture; fabricated ones say "yes, always, ten out of ten" to everything.
- **Textbook recitation.** Symptoms delivered in diagnostic-manual language, in diagnostic-manual order. That's what a script sounds like. Real patients describe their lives, not criteria.
- **Presentation mismatch.** Reporting you can barely leave the house, then chatting easily about your bowling league. Claiming crippling memory loss, then recounting your service history in precise detail.
- **Failed validity testing.** Mental health exams often include embedded validity measures. You can't out-think instruments designed by people who study malingering for a living. Don't try.
- **Effort mismatch on physical testing.** Give-way weakness, wildly variable measurements across trials, "impossible" exam findings.

When a report includes language like "symptom exaggeration" or "results invalid due to inconsistent effort," the damage spreads. The rater discounts the exam, doubts your statements, and reads the rest of your file through squinted eyes. And if it rises to actual fraud, you're risking criminal exposure and every dollar of legitimate benefit you've earned. There is no rating percentage worth that.

If you've been honest all the way through this book — documenting real symptoms since Part II — you have nothing here to worry about. This section isn't for you. It's for the buddy who's about to tell you to "just say you can't sleep at all." Hand him this chapter.

Mistake 6: Fighting the Examiner

Some exams are rushed. Some examiners are cold, dismissive, or seem to have skimmed your file at a red light on the way in. It's infuriating — you waited months for this.

Do not go to war in the exam room. Arguing, lecturing the examiner about 38 CFR, or demanding they write things down a certain way accomplishes exactly one thing: it shows up in the report, and not in your favor. "Veteran was hostile and confrontational" is a sentence that follows you.

Stay squared away. Answer everything fully. If the exam is genuinely inadequate — key conditions never examined, measurements skipped, your answers cut off — your remedy is documentation and rebuttal, not confrontation. Note the specifics immediately afterward, while it's fresh. Chapter 21 shows you exactly how to challenge a bad exam the right way, and a calm, professional veteran with contemporaneous notes wins that fight far more often than an angry one.

Mistake 7: Logistics Failures

Quick-fire, because these are dumb ways to lose:

- ☐ Don't no-show. Ever. (Chapter 18 covered why — it can end the claim.)
- ☐ Confirm the address the day before; contractors use multiple offices.
- ☐ Arrive early with photo ID and your appointment letter.
- ☐ Handle childcare and transportation in advance — "I couldn't get a ride" is a bad reason to lose a claim you spent two years building.
- ☐ Silence your phone; give the exam your full attention.
- ☐ Immediately afterward, write down what was examined, what was asked, and anything that felt wrong or incomplete.

The Thread Running Through All of It

Look back at the seven mistakes. Minimizing understates the truth. Good-day performances sample the wrong slice of it. Forgetting flare-ups omits it. Inconsistency scrambles it. Exaggeration abandons it. Fighting the examiner buries it under noise, and logistics failures mean it never gets heard at all.

Every mistake is a different way of failing to deliver the accurate, complete truth. Which means every fix is the same: know your own case cold, and tell it straight. You've been building toward that since the first sick-call visit in Part II.

Key Takeaways

- "I'm fine" is the most expensive sentence in the claims process — describe your real life, not your motor-pool answer.
- Speak up when pain starts during range-of-motion testing, and put your flare-ups and work impact on the record even if nobody asks.
- Reread your statements and symptom log before the exam so your honest testimony matches your honest paperwork.
- Exaggeration red flags — over-endorsement, scripted answers, presentation mismatches, failed validity tests — poison your whole file. Truth is both the ethical play and the winning one.
- Never argue with a bad examiner in the room; document the gaps immediately and rebut through the process (Chapter 21).
- Treat exam logistics like a mission: confirmed, early, prepared, phone off.

END OF SAMPLE

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