STUDENT COUNSELING AND PSYCHOLOGICAL SERVICES (S-CAPS)
FAIRLEIGH DICKINSON UNIVERSITY

Name: _____ **Date**_____

Prior Mental Health/Substance Use Treatment (please circle)

At FDU? Y N
If yes, where? _____

Elsewhere? Y N
If yes, where? _____

Do you have a disability? Y N
What type?_____
Have you ever had a head injury? Y N
When?_____

Ethnic Identification:_____

Religious affiliation:_____

Are you a Transfer Student ? Y N
If yes, from where?
_____
_____

Residence:
___ Residence Hall
___ Off-campus (local)
___ Off-campus (from home)
___ Frat/Sorority

Major _____
Current Credit Load_____
Current GPA_____
Regularly Attending Classes? YES NO
Nonacademic work (hrs/wk)_____
Type of work _____
Regularly Attending Work? YES NO

Living Situation:
___ Alone
___ Roommate(s)
___ Partner/spouse
___ Parent(s)
___ Other

Partner Status:
___ Single
___ Married
___ Partnered
___ Separated
___ Divorced
___ Widow/Widower

Please list up to three problems or reasons you had for coming to counseling today. Then rate how upsetting each problem is to you, and how long it has been troubling you.

Problem	**How upsetting?**	**How long?**
_____	1_____3_____5	_____
_____	1_____3_____5	_____
_____	1_____3_____5	_____
	Mild Moderate Severe	

What made you decide to call for an appointment now (as opposed to earlier, or attempting to continue to cope on your own)? Please include your own reasons, as well as any urging or pressure you experienced from others: /who referred you to counseling

_____

_____

Please list the names of medical and psychiatric medications, dosages, dates when they were prescribed, and by whom:

1. _____ Dose: _____ Date: _____ Prescriber:_____
2. _____ Dose: _____ Date: _____ Prescriber:_____
3. _____ Dose: _____ Date: _____ Prescriber:_____

Use space on back if needed.

Have you experienced any significant personal/emotional difficulties before now? If so, please tell us something about that time of your life:

_____

_____

Does any member of your immediate or extended family suffer from an emotional or mental difficulty (such as alcoholism, depression, anxiety, bipolar disorder)? If so, what kind of difficulty? Did they receive treatment? How successful was it?

_____

_____

How often do you drink alcohol? Never Monthly or less 2-4xx/month 4 or more xx/wk

How often do you have 4 or more drinks on one occasion? Never Less than monthly Monthly Weekly Daily or Almost daily

How often do you use other drugs? Never Monthly or less 2-4xx/month 4 or more xx/wk

Please list the members of your immediate family and their ages:

Name	Relationship to you	Age
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

How would you describe your childhood?

_____

_____

Did you have a family nickname, reputation or role (e.g. the smart one, the mediator, the black sheep)?

_____

_____

Who are the most significant people in your life, and what is their relationship to you?

_____

_____

_____

Please check all that apply for you:

___Detached
___Nightmares
___Flashbacks
___Jumpiness
___Experienced
abuse and/or trauma

____Compulsivity
____Obsessive thoughts

____Overeating
____Over-exercising
____Nausea/vomiting

___Disorganized
___Distracted
___Unmotivated
___Impulsive
___Reckless
___Poor Concentration
___Procrastination
___Skipping Classes
___Violent fantasies or thoughts
___ Physical aggressive to self or others
___ Anger management problems

Please list any medical conditions:_____

_____

_____

Please briefly describe your earliest memory:

_____

_____

_____

_____

_____

_____

_____

	Never	Sometimes	Often	Always
Section II				
1. In the past 12 months, have you had 3 or more alcoholic drinks within a 3 hour period on 3 or more occasions?				
If your answer to this question is "NO," you have completed Section II, please do not answer the questions below. Please proceed to Section III.				
2. In the past 12 months: a. Did you need to drink more in order to get the same effect that you got when you first started drinking?				
b. When you cut down on drinking, did you hands shake, did you sweat or feel agitated? Did you drink to avoid these symptoms? (If yes to either, please check "YES.")				
c. During the times when you drank alcohol, did you end up drinking more than you planned when you started?				
d. Have you tried to reduce or stop drinking alcohol but failed?				
e. On the days that you drank, did you spend substantial time in obtaining alcohol, drinking, or in recovering from the effects of alcohol?				
f. Did you spend less time working, enjoying hobbies, or being with others because of your drinking?				
g. Have you continued to drink even though you knew that it caused you problems?				

	Never	Sometimes	Often	Always
Section III				
1. Have you, on more than one occasion, had spells or attacks when you suddenly felt anxious, frightened, uncomfortable or uneasy, even in situations where most people would not feel that way? Did the spells peak within 10 minutes? (If yes to either, please check "YES.")				
2. At any time in the past, did any of those spells or attacks come on unexpectedly or occur in an unpredictable or unprovoked manner?				
If your answer to both questions above is "NO," please proceed to Section IV without answering any other questions below in Section III.				
3. During the worst spell that you can remember: a. Did you have skipping, racing, or pounding of your heart?				
b. Did you have sweating or clammy hands?				
c. Were you trembling or shaking?				
d. Did you have shortness of breath or difficulty breathing?				
e. Did you have a choking sensation or a lump in your throat?				
f. Did you have chest pain, pressure, or discomfort?				
g. Did you have nausea, stomach problems or sudden diarrhea?				
h. Did you feel dizzy, unsteady, lightheaded or faint?				
i. Did things around you feel strange, unreal, detached or unfamiliar, or did you feel outside or detached from part, all of you body?				
j. Did you fear that you were losing control or going crazy?				
k. Did you fear that you were dying?				
l. Did you have tingling or numbness in parts of your body?				
m. Did you have hot flushes or chills?				
4. In the past month, did you have such attacks repeatedly (2 or more) followed by persistent fear of having another attack?				

Section IV	Never	Sometimes	Often	Always
1. In the past month, were you fearful or embarrassed by being watched or being the focus of attention, or fearful of being humiliated? This includes things like speaking in public, eating in public alone or with others, writing while someone watches, or being in social situations?				
2. Is this fear excessive or unreasonable?				
3. Do you fear these situations so much that you avoid them or suffer through them?				
4. Does this fear disrupt your normal work or social functioning or cause you significant distress?				

Have you <u>ever</u> had:	**Never**	**More than 6 mos. Ago**	**In the past 6 mos.**
11. a <u>week or more</u> of sustained, excited, unusually elevated mood, like a "high," out-of-control behavior (such as risky sex, binge drinking, over-spending), racing thoughts, and little need for sleep?			
12. a <u>week or more</u> of sustained, *excessively* irritable mood, with anger, arguments, or breaking things, that led to difficulties with others?			

Have you ever had:	**No**	**Yes**
13. any close blood relative (parent, child, sister, brother) with depression, manic-depression, alcohol abuse, or who was psychiatrically hospitalized?		

For the past <u>two weeks</u> please write in your use of recreational drugs or alcohol:

WEEK 1

Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Substance and How much	Substance and How much	Substance and How much	Substance and How much	Substance and How much	Substance and How much	Substance and How much

WEEK 2

Mon	Tues	Wed	Thurs	Fri	Sat	Sun
Substance and How much	Substance and How much	Substance and How much	Substance and How much	Substance and How much	Substance and How much	Substance and How much

****

Please let us know the days and times you are available to come in for appointments. We schedule appointments Monday through Friday 9:00 am to 4:00 pm. We encourage you to arrive at least 5 minutes before your scheduled time:

Monday:

Tuesday:

Wednesday:

Thursday:

Friday: