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

Name: _____ **Date**_____

Prior Mental Health and/or Substance Use Treatment:
(please circle)

At FDU? Y N
If yes, when? _____

Elsewhere? Y N
If yes, *where and when*? _____

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)
___ Other_____

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

Sexual Orientation:
_____
Gender Identity:
_____
Preferred Pronoun:
_____

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 (***use space on back if additional is needed***):

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

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?

_____

_____

Do you use any alcohol, marijuana, or other drugs? _____

Does Internet, Cell phone, or Videogaming use interfere with your social or academic performance? / **if so, How**?_____

_____

Please list the members of your immediate family and their ages (***if additional family members list on back of page***):

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/Numb
___Nightmares
___Flashbacks
___Jumpiness
___Experienced abuse and/or trauma

____Obsessive thoughts
____Compulsive behaviors/rituals
Describe:_____
_____

____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:

_____
_____
_____
_____
_____
_____

The Cannabis Use Disorder Identification Test - Revised (CUDIT-R)

Have you used any cannabis over the past six months? Yes_____ No _____

If you answered "Yes" to the previous question, please answer the following questions about your cannabis use. Circle the response that is most correct for you in relation to your cannabis use over the *past six months.*

1. How often do you use cannabis?

Never	Monthly or less	2-4 times a month	2-3 times a week	4+ times a week
0	1	2	3	4

2. How many hours were you "stoned" on a typical day when you had been using cannabis?

Less than 1	1 or 2	3 or 4	5 or 6	7 or more
0	1	2	3	4

3. How often during the past 6 months did you find that you were not able to stop using cannabis once you had started?

Never	Less than monthly	Monthly	Weekly	Daily/almost daily
0	1	2	3	4

4. How often during the past 6 months did you fail to do what was normally expected from you because of using cannabis?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

5. How often in the past 6 months have you devoted a great deal of your time to getting, using, or recovering from cannabis?

Never	Less than monthly	Monthly	Weekly	Daily/almost daily
0	1	2	3	4

6. How often in the past 6 months have you had a problem with your memory or concentration after using cannabis?

Never	Less than monthly	Monthly	Weekly	Daily or almost daily
0	1	2	3	4

7. How often do you use cannabis in situations that could be physically hazardous, such as driving, operating machinery, or caring for children?

Never	Less than monthly	Monthly	Weekly	Daily/almost daily
0	1	2	3	4

8. Have you ever thought about cutting down, or stopping, your use of cannabis?

Never	Yes, but not in the past 6 months	Yes, during the past 6 months
0	2	4

This questionnaire was designed for self-administration and is scored by adding each of the 8 items:

Question 1-7 are scored on a 0-4 scale
Question 8 is scored 0,2, or 4

Score: _____

Scores of 8 or more indicate hazardous cannabis use, while scores of 12 or more indicate a possible cannabis use disorder for which further intervention may be required.

Adamson SJ, Kay-Lambkin FJ, Baker AL, Lewin TJ, Thornton L, Kelly BJ, and Sellman JD. (2010). An Improved Brief Measure of Cannabis Misuse: The Cannabis Use Disorders Identification Test – Revised (CUDIT-R). *Drug and Alcohol Dependence* 110:137-143.

Alcohol screening questionnaire (AUDIT)

Our clinic asks all patients about alcohol use at least once a year. Drinking alcohol can affect your health and some medications you may take. Please help us provide you with the best medical care by answering the questions below.

Patient name: _____

Date of birth: _____

One drink equals: 12 oz. beer | 5 oz. wine | 1.5 oz. liquor (one shot)

1. How often do you have a drink containing alcohol?	Never	Monthly or less	2 - 4 times a month	2 - 3 times a week	4 or more times a week
2. How many drinks containing alcohol do you have on a typical day when you are drinking?	0 - 2	3 or 4	5 or 6	7 - 9	10 or more
3. How often do you have four or more drinks on one occasion?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
4. How often during the last year have you found that you were not able to stop drinking once you had started?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
5. How often during the last year have you failed to do what was normally expected of you because of drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
6. How often during the last year have you needed a first drink in the morning to get yourself going after a heavy drinking session?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
7. How often during the last year have you had a feeling of guilt or remorse after drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
8. How often during the last year have you been unable to remember what happened the night before because of your drinking?	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
9. Have you or someone else been injured because of your drinking?	No		Yes, but not in the last year		Yes, in the last year
10. Has a relative, friend, doctor, or other health care worker been concerned about your drinking or suggested you cut down?	No		Yes, but not in the last year		Yes, in the last year
	0	1	2	3	4

Have you ever been in treatment for an alcohol problem? ☐ Never ☐ Currently ☐ In the past

HAVE YOU EVER HAD?	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 ever had:	Never	In the past 6 months?	More than 6 months ago?
5. A week or more 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?			
6. A week or more of sustained, *excessively* irritable mood, with anger, arguments, or breaking things, that led to difficulties with others?			

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