

**MEDICAL UNIVERSITY OF SOUTH CAROLINA  
CAPS Information Form for Spouses/Partners**

This form assists the therapist in determining the best course of action for you and your spouse/partner. It will take approximately 30 minutes to complete. Please allow sufficient time to complete in one setting prior to your appointment in CAPS. If you have any questions, please call the CAPS Office at 843-792-4930 during office hours.

**CONTACT INFORMATION:**

First Name \_\_\_\_\_  
Last Name \_\_\_\_\_  
Date of Birth \_\_\_\_\_  
Maiden Name (if applicable) \_\_\_\_\_  
Preferred Name (if applicable) \_\_\_\_\_  
Spouse/Partner's Name \_\_\_\_\_

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION?

\_\_\_ YES \_\_\_ NO

IF YES, WHOM: \_\_\_\_\_  
PHONE NUMBER: \_\_\_\_\_

What is the relationship issue for which you are seeking counseling?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Relationship difficulties often interfere with different aspects of your life. Please rate how much your relationship difficulties have interfered with each of the following areas of your life during the past seven days (including today).

Academic/occupational functioning:

- Not at all (or not applicable)
- Slightly
- Somewhat
- Pretty much
- Very much

Social/interpersonal functioning:

- Not at all (or not applicable)
- Slightly
- Somewhat
- Pretty much
- Very much

Functioning in everyday activities (e.g., exercise, paying bills, maintenance of health, etc.):

- Not at all (or not applicable)
- Slightly
- Somewhat
- Pretty much
- Very much

Have you or your partner engaged in any of the following behaviors:

- Hitting
- Pushing
- Restraining
- Slapping
- Throwing objects

Have you experienced any significant life changes in the past year?

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What is the biggest source of stress in your life?

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Are you currently having thoughts of physically harming or killing yourself?

- Yes
- No

Have you previously had thoughts of physically harming or killing yourself?

- Yes
- No

Are you currently having thoughts of physically harming or killing another person?

- Yes
- No

Have you previously had thoughts of physically harming or killing another person?

- Yes
- No

**EDUCATION**

High School

Name of high school from which you graduated \_\_\_\_\_  
High School Location (City, State) \_\_\_\_\_  
Year Graduated \_\_\_\_\_  
High School GPA \_\_\_\_\_

Undergraduate

Name of Undergraduate College \_\_\_\_\_  
Location (City, State) of Undergraduate College \_\_\_\_\_  
Year Graduated \_\_\_\_\_  
Undergrad GPA \_\_\_\_\_  
Undergraduate Degree(s) \_\_\_\_\_  
Undergraduate Major \_\_\_\_\_

Please complete if you attended more than one undergraduate institution)

Name of Undergraduate College \_\_\_\_\_  
Location (City, State) of Undergraduate College \_\_\_\_\_  
Year Graduated \_\_\_\_\_  
Undergrad GPA \_\_\_\_\_  
Undergraduate Degree(s) \_\_\_\_\_  
Undergraduate Major \_\_\_\_\_

Graduate

Graduate School Name (other than MUSC) \_\_\_\_\_  
Graduate School Location (City, State) \_\_\_\_\_  
Graduate Degree(s) \_\_\_\_\_  
Graduate Major \_\_\_\_\_

**EMPLOYMENT HISTORY**

List all FULL-TIME positions since leaving high school. Include company, job description, start/end dates, and reason(s) for leaving.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**MILITARY SERVICE**

Are you a member of the United States Armed Forces?

- no
- veteran
- active duty
- reserves
- national guard

**If yes, which branch of the Armed Forces?**

- Air Force
- Army
- Coast Guard
- Marine Corps
- Navy

Please indicate your dates of service. \_\_\_\_\_ / \_\_\_\_\_ to \_\_\_\_\_ / \_\_\_\_\_

**MARITAL AND FAMILY STATUS**

Current Marital Status (check all that apply)

- Single, never married
- Single, significant relationship
- Married
- Separated
- Divorced
- Widow/widower

If married or previously married, date of marriage. \_\_\_\_\_

If divorced, date of divorce. \_\_\_\_\_

What is your Sexual Orientation

- Heterosexual
- Bisexual
- Homosexual
- Asexual
- No answer/Prefer not to respond
- Other \_\_\_\_\_

**Children**

Number of boys \_\_\_\_\_

Number of girls \_\_\_\_\_

**Names and ages of children**

(Please note if the child is from a previous marriage, adopted, step-child, or foster child.)

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Do your children live with you?

- full-time
- part-time
- visitation, but do not live with me at any time
- no visitation and do not live with me

**MEDICAL HISTORY**

Height in feet/inches (example: 5' 7") \_\_\_\_\_

Weight (pounds)

Please describe any medical conditions, serious illnesses, accidents, operations you currently have or have had in the past and note your age at onset as well as treatment you received.

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Please describe any mental health conditions you have experienced, including date of onset hospitalization, treatment, therapist, psychiatrist, etc.

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Please list any psychotropic medications that you are currently taking (e.g., Ativan, Ritalin, Lithium, Prozac, Adderall, etc.). Please include dosage and why they were prescribed.

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Please list any psychotropic medications that have taken in the past (e.g., Ativan, Ritalin, Lithium, Prozac, Adderall, etc.). Note dosage and date ended.

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Please list any current non-psychotropic medications (including over-the-counter, prescription, herbal/dietary supplements) that you are taking.

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**FAMILY HISTORY**

Are your parents living?

- Both parents are living
- Both parents are deceased
- Mother is living, Father is deceased
- Father is living, Mother is deceased

If applicable, date of death - Mother

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If applicable, date of death - Father

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Mother - Highest level of education

- Elementary
- High school
- College
- Graduate

Mother - Occupation

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Father - Highest level of education

- Elementary
- High school
- College
- Graduate

Father - Occupation

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Which of these best describes your parents' marital status?

- Married, living together
- Married, living apart
- Unmarried, living together
- Unmarried, living apart
- Separated
- Divorced
- Widowed
- Both parents are deceased

Please list the names, ages, gender of your siblings and indicate the biological relationship (step-sister/brother; half-sister/brother; adopted sister/brother, etc.).

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**FAMILY MEDICAL HISTORY**

Please indicate which of the following conditions your biological MOTHER has/had

- Medical disease
- Mental health issue (psychosis, mania, depression, anxiety, etc.)
- Learning/Attention problem
- Excessive alcohol use
- Excessive drug use
- None that I am aware of
- Unknown

Please provide details if you checked any of the above conditions concerning your biological mother.

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Please indicate which of the following conditions your biological FATHER has/had

- Medical disease
- Mental health issue (psychosis, mania, depression, anxiety, etc.)
- Learning/Attention problem
- Excessive alcohol use
- Excessive drug use
- None that I am aware of
- Unknown

Please provide details if you checked any of the above conditions concerning your biological father.

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Please indicate which of the following conditions your biological SIBLING(s) has/had

- Mental health issue (psychosis, mania, depression, anxiety, etc.)
- Medical disease
- Learning/Attention problem
- Excessive alcohol use
- Excessive drug use
- None that I am aware of
- Unknown

Please provide details if you checked any of the above conditions concerning your biological sibling(s).

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Please indicate which of the following conditions your biological GRANDPARENT(S), AUNT, UNCLE, COUSINS has/had

- Medical disease
- Mental health issue (psychosis, mania, depression, anxiety, etc.)
- Learning/Attention problem
- Excessive alcohol use
- Excessive drug use
- None that I am aware of
- Unknown
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Please provide details if you checked any of the above conditions concerning your biological GRANDPARENT(S), AUNT, UNCLE, COUSINS.

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## PERSONAL INVENTORY

Please read each of the following questions/statements and check the box that BEST applies to you.

**Section 1.** Which of the following problems have you ever experienced nearly every day for a two-week period?

	Yes	No
A depressed mood most of the day		
Significant weight loss or gain which was unintentional		
Trouble falling asleep, trouble staying asleep, or sleeping too much		
Fatigue or loss of energy		
Diminished interest or pleasure in most activities		

**Section 2.** Which of the following describe(s) you?

	Yes	No
Preoccupied with food and eating		
Purge (vomit) after eating		
Go on an eating binge(s) during which I consume larger amounts of food than most people would eat		
At times I feel as though I have no control over my eating		
I have used laxatives and/or diuretics in an attempt to control my weight		
I avoid eating certain foods such as sweets or fried foods		

**Section 3.** Describing an episode or spell during which you suddenly felt afraid or very anxious for no apparent reason.

	Yes	No
Have you ever experienced an episode or spell during which you suddenly felt afraid or very anxious for no apparent reason?		(If "no", skip to Section 4)
During the episode, did you experience sweating?		
During the episode, did you experience trembling or shaking?		
During the episode, did you experience chest pain?		
During the episode, did you experience shortness of breath?		
During the episode, did you experience nausea?		
During the episode, did you experience dizziness or light-headedness?		
During the episode, did you experience numbness or tingling in your hands and face?		
Did the fear you experienced during the episode reach a peak within 10 - 60 minutes?		

**Section 4. Social Situations**

	Yes	No
Have you ever experienced an intense or persistent fear of a social situation or a situation that required you to perform in front of others?		
Have you ever experienced an intense or persistent fear of a situation in which you thought others might be judging or evaluating you?		
If you are placed in a feared social situation, do you experience intense anxiety?		
Do you believe that your fear of social situations is excessive or unreasonable?		
Do you avoid feared social or performance situations or endure them with intense anxiety?		
Do you fear in social situations that you will be humiliated or embarrassed by your actions?		

**Section 5. Thoughts, Images, Impulses**

	Yes	No
Have you ever been bothered by unwanted, persistent thoughts, images, or impulses that seemed silly or horrible?		
Have you ever been bothered by a persistent thought or impulse that seemed unreasonable or excessive?		
Have you ever felt bothered by thoughts, images, or impulses that you couldn't get out of your mind and that caused you to experience intense anxiety?		
Have you ever felt compelled to repeat certain behaviors (e.g., hand-washing) or thoughts (e.g., counting or repeating words)?		
Do you keep many useless things, not because you need them but because you cannot throw them away?		
Do you wash yourself or other things excessively?		
Do you worry excessively about germs or dirt?		
Do you have to check things again and again to be sure that they were done correctly?		

**Section 6. Drinking**

	Yes	No
Do you think you are a normal drinker?		
Do friends or relatives think you are a normal drinker?		
Have you ever attended a meeting of Alcoholics Anonymous?		
Have you ever lost friends or damaged a romantic relationship because of your drinking?		
Have you ever gotten into trouble at work or been late to work because of your drinking?		
Have you ever gone to anyone for help about your drinking		
Have you ever been in a hospital because of your drinking?		
Have you ever been arrested for drunk-driving or driving after drinking		
Have you ever thought you should cut down on your drinking		
Has anyone ever complained about your drinking?		
Have you ever felt guilty or upset about your drinking?		
Has there ever been a single day in which you had 5 or more drinks of beer, wine, or liquor?		

**Section 7. Appearance**

	Yes	No
Are you preoccupied with the desire to be thinner?		
Do people think you are too thin?		
Do others frequently urge you to eat more?		
Do you avoid eating when you are hungry?		
Are you afraid of being overweight?		
Do you weigh yourself frequently?		
Do you think you are overweight, although others tell you that you appear thin?		
Do you try on key items of clothing to make sure you have not gained weight?		

**Section 8. Worrying**

	Yes	No
Have you ever experienced excessive anxiety or worry, occurring more days than not for at least six months?		
Do you find it difficult to control your worrying?		
Do you worry unreasonably or excessively about many different things (e.g., work, school, family members)?		
Does anxiety interfere with your ability to perform your daily activities?		
When you are worrying or feeling anxious, do you experience restlessness or feeling on edge?		
When you are worrying or feeling anxious, do you experience being easily fatigued?		
When you are worrying or feeling anxious, do you experience difficulty in concentrating?		
When you are worrying or feeling anxious, do you experience irritability?		
When you are worrying or feeling anxious, do you experience muscle tension?		
When you are worrying or feeling anxious, do you experience difficulty in falling or staying asleep?		

**Section 9. Distress**

	Yes	No
Have you ever experienced or witnessed an event that involved actual or threatened death or serious injury to yourself or others that cause intense fear or horror (e.g., a severe car accident, childhood physical or sexual abuse, rape, assault, etc.)?		(If no, skip to Section 10)
Do you re-experience the event through repeated distressing memories or dreams?		
Do you re-experience the event through acting or feeling as if the traumatic event were recurring (e.g., flashbacks, reliving the event, etc.)?		
Do you re-experience the event through intense psychological distress or physiological arousal when exposed to things that remind you of the traumatic event?		
Do you avoid things that remind you of the traumatic event (e.g., activities, places, or people)?		
Are you unable to recall an important aspect of the traumatic event?		
Since the traumatic event occurred, have you experienced diminished interest or participation in activities you previously enjoyed?		

Since the traumatic event occurred, have you experienced a sense of detachment or estrangement from others?		
Since the traumatic event occurred, have you experienced persistent symptoms of increased physiological arousal as indicated by difficulty sleeping?		
Since the traumatic event occurred, have you experienced persistent symptoms of increased physiological arousal as indicated by irritability or outbursts of anger?		
Since the traumatic event occurred, have you experienced persistent symptoms of increased physiological arousal as indicated by decreased concentration?		

**Section 10. Control of Thoughts, Feelings, Actions**

	Yes	No
Have you ever been hospitalized for a psychiatric disorder?		
Have you ever experienced a period of time during which you were paranoid, thinking that other people were talking about you or were out to get you?		
Have you ever experienced a period of time during which you felt as though your thoughts, feelings, or actions were being controlled by some outside force?		
Have you ever experienced a period of time during which you heard voices when no one was present?		
Have you ever experienced a period of time during which you saw a vision or something else that others were unable to see?		
Have you had an experience during which you felt that people on the radio or TV were talking to you or about you?		
Have you ever had an experience during which you thought that others could read your mind?		

**Section 11. Mood, Self-esteem, Impulsiveness**

	Yes	No
Have you ever had a period of one week or more during which you experienced an abnormally happy or irritable mood?		
Have you ever had a period of one week or more during which you experienced an inflated sense of self-esteem or thought you had special powers?		
Have you ever had a period of one week or more during which you needed much less sleep than is usual for you and did not feel sleepy?		
Have you ever had a period of one week or more during which you felt as though your thoughts were racing or you were unusually talkative?		

Have you ever had a period of one week or more during which you were "hyper," agitated, or started too many projects at once?		
Have you ever experienced a one-week period of time during which you were very impulsive or became involved in activities which caused your family or friends to be worried about you?		

**Section 12.1 Alcohol Use**

In the past 30 days, on how many occasions did you drink alcohol?

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20+

In the past 30 days, how many times did you have 5 or more drinks in a row?

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20+

On occasions when you drink alcohol, how many drinks do you have on average?

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20+

**Section 12.2 Drug Use**

Lifetime use (# of occasions) of amphetamines, excluding those prescribed for you.

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20 - 39
- 40+

Lifetime use (# of occasions) of cocaine

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20 - 39
- 40+

Lifetime use (# of occasions) of hallucinogens

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20 - 39
- 40+

Lifetime use (# of occasions) of marijuana/hashish

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20 - 39
- 40+

Lifetime use (# of occasions) of heroin

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20 - 39
- 40+

Lifetime use (# of occasions) of other drugs

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20 - 39
- 40+

Past year use (# of occasions) of amphetamines, excluding those prescribed for you.

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20 - 39
- 40+

Past year use (# of occasions) of cocaine

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20 - 39
- 40+

Past year use (# of occasions) of hallucinogens

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20 - 39
- 40+

Past year use (# of occasions) of marijuana/hashish

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20 - 39
- 40+

Past year use (# of occasions) of heroin

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20 - 39
- 40+



Past year use (# of occasions) of other drugs

- 0
- 1 - 2
- 3 - 4
- 5 - 6
- 7 - 9
- 10 - 19
- 20 - 39
- 40+

**Section 12.3 Tobacco Use**

	Yes	No
In the past 30 days, have you smoked cigarettes		
In the past 30 days, have you smoked cigars?		
In the past 30 days, have you smoked a pipe?		
In the past 30 days, have you used smokeless tobacco?		

How many times a day do you use tobacco (on average)? \_\_\_\_\_

**Section 12.4 Caffeine**

	Yes	No
Do you drink caffeinated beverages regularly (in the past 30 days)?		

Approximately how many 8-oz. caffeinated drinks per day on average do you consume? \_\_\_\_\_

**Section 12.5 Exercise**

On average, how many days a week do you get some form of exercise? \_\_\_\_\_

**ADDITIONAL INFORMATION**

Please add any additional information that you think would be helpful in understanding your problems and/or concerns.

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