MEDICAL UNIVERSITY OF SOUTH CAROLINA
CAPS New Client Information Form

Students coming for their first CAPS visit are asked to complete the CAPS New Client Information Form. This form takes approximately 20 minutes to complete. The information on this form will allow your provider at CAPS to structure your first session more efficiently and effectively, and provide the best care.

We ask that you complete the CAPS New Client Information Form at least 24 hours prior to your scheduled appointment. This will allow your provider at CAPS enough time to review it before your appointment. If you are unable to complete the form at least 24 hours prior to your appointment, your appointment may need to be rescheduled since this information is essential to providing good care.

If you have any questions regarding this form or your appointment, please call the CAPS Office at 843-792-4930 during office hours.

CONTACT INFORMATION:

First Name _____
Last Name _____
Maiden Name (if applicable) _____
Preferred Name (if applicable) _____

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: _____

Briefly state the nature of your current concern or problem.

_____
_____
_____
_____
_____
_____
_____

The types of problems people seek help for at counseling centers often interfere with different aspects of their lives. Please rate how much the problem for which you are seeking help at CAPS has interfered with each of the following areas of your life in the past seven days (including today).

How much has the problem for which you are seeking help interfered with your academic/occupational functioning in the past 7 days?

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

How much has the problem for which you are seeking help interfered with your social/interpersonal functioning in the past 7 days?

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

How much has the problem for which you are seeking help interfered with your functioning in everyday activities (e.g., exercise, paying bills, maintenance of health, etc.) in the past 7 days?

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

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

What is the biggest source of stress in your life?

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

Please select your current MUSC College.

MUSC College

- ❒ Dentistry
- ❒ Graduate Studies
- ❒ Health Professions
- ❒ Medicine
- ❒ Nursing
- ❒ Pharmacy

Program _____
e.g., PA, Nurse Practitioner, OT, PT, MSTP, etc.)

In what year of your program are you currently enrolled?

- ❒ 1st year
- ❒ 2nd year
- ❒ 3rd year
- ❒ 4th year
- ❒ 5th year
- ❒ 6th year
- ❒ 7th year
- ❒ 8th year
- ❒ I am currently on a leave of absence

If you are currently on a leave of absence, briefly state when you began your leave and the reason(s) for your leave.

_____
_____
_____
_____

Is your visit to CAPS required by your college?

❒ No
❒ Yes
If yes, please explain. _____
_____

Are you a previous client at CAPS?

❒ No
❒ Yes

If yes, when was your last visit? (Month/Year) _____ / _____

Referred to CAPS by

- ❒ Self
- ❒ Academic Dean (Name of dean who referred you to CAPS) _____
- ❒ Faculty Member (Name of faculty member who referred you to CAPS) _____
- ❒ Friend
- ❒ Relative
- ❒ Class Presentation
- ❒ Other

Name of individual who referred you to CAPS?_____

What type(s) of services are you seeking at CAPS? (check all that apply)

- ❒ Individual counseling
- ❒ Couples Counseling
- ❒ Medication Management and Counseling
- ❒ Medication Management Only
- ❒ Testing accommodations
- ❒ Testing for problems affecting learning
- ❒ Other

If other, please explain.

_____
_____
_____

EDUCATION

<u>High School</u>

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

<u>Undergraduate</u>

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 _____

Spouse/Partner Information

Spouse/partner First Name _____
Spouse/partner Last Name _____
Spouse/partner Occupation _____

How would you best describe the working hours of your spouse/partner?

- ❒ full time
- ❒ part-time
- ❒ occasional
- ❒ does not work at this time
- ❒ disabled
- ❒ retired

Spouse/partner highest level of education

- ❒ Elementary school
- ❒ High school
- ❒ College (did not graduate)
- ❒ College (graduated)
- ❒ Graduate school

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.)

_____
_____
_____
_____
_____

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.

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

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.

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

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

_____
_____
_____
_____
_____

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 _____
If applicable, date of death - Father _____

Mother - Highest level of education

- ❒ Elementary
- ❒ High school
- ❒ College
- ❒ Graduate

Mother - Occupation _____

Father - Highest level of education

- ❒ Elementary
- ❒ High school
- ❒ College
- ❒ Graduate

Father - Occupation _____

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.).

_____
_____
_____
_____
_____

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.

_____
_____
_____

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.

_____
_____
_____

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).

_____
_____
_____

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

Please provide details if you checked any of the above conditions concerning your biological GRANDPARENT(S), AUNT, UNCLE, COUSINS.

_____
_____
_____

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 60 days, on how many occasions did you drink alcohol?

- ❒ 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+

In the past 60 days, did you have…

Women

- ❒ more than 3 drinks in any one day
- ❒ more than 7 drinks per week

Men

- ❒ more than 4 drinks in any one day
- ❒ more than 14 drinks per week

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.

_____
_____
_____
_____
_____
_____
_____