CAPS First Contact Questionnaire

If you are in crisis or feeling suicidal, please schedule an immediate appointment with CAPS at 320-308-3171 or call 911. This intake form is designed to collect information in preparation for your appointment and may not be reviewed in a timely manner.

Name:_____ **Student ID#:**_____

Briefly describe the concerns that led you to seek counseling.

Personal and Demographic Information

What kind of housing do you currently have?_____
Who do you live with?_____
What is your relationship status?_____
What is your gender identity? _____
What is your sexual orientation?_____
What are your pronouns? _____
What is your race/ethnicity?_____
What is your country of origin? _____
If you are an undergraduate, what is your major?_____
If you are a graduate student, what is your graduate program? _____
Did you transfer from another campus/institution? ☐ Yes ☐ No
Does your religious or spiritual preference play an important role in your life? ☐ Yes ☐ No
Do you have any conditions that may interfere with your participation in counseling (i.e. language barrier, disability, etc.) ☐ Yes ☐ No
Are you registered with the office for disability services on this campus, as having a documented and diagnosed disability? ☐ Yes ☐ No
If yes to the above question, please list which category of disability you are registered for.

Family History

Are you the first in your family to attend college? ☐ Yes ☐ No
Do you have any children? ☐ Yes ☐ No
Please indicate how much you agree with this statement: "I get the emotional help and support I need from my family."
☐ Strongly disagree ☐ Somewhat disagree ☐ Neutral ☐ Somewhat agree ☐ Strongly agree

How would you describe your financial situation growing up?
☐ Never stressful ☐ Rarely stressful ☐ Sometimes stressful ☐ Often stressful ☐ Always stressful

Developmental History

When you were born, were there any birth complications you are aware of? ☐ Yes ☐ No
Did you have any developmental delays (crawling, walking, talking, toilet training, socializing)? ☐Yes ☐ No
Did you ever have an IEP (Individualized Education Plan) in school? ☐ Yes ☐ No
Do you have history of Learning Disability? ☐ Yes ☐ No

Employment and Extra-Curriculars

If you participate in any organized college athletic programs, please list them.

If you participate in any extra-curricular activities, please list them.

Are you in Reserve officers' Training Corps (ROTC)? ☐ Yes ☐ No
Do you have any history of military service? ☐ Yes ☐ No
Are you currently employed? ☐ Yes ☐ No
If yes, how many hours per week do you work? _____
Do you have any current or pending legal issues? ☐ Yes ☐ No

How would you describe your financial situation right now?
☐ Never stressful ☐ Rarely stressful ☐ Sometimes stressful ☐ Often stressful ☐ Always stressful

Please indicate how much you agree with this statement: "I get the emotional help and support I need from my social network (e.g. friends & acquaintances)."
☐ Strongly disagree ☐ Somewhat disagree ☐ Neutral ☐ Somewhat agree ☐ Strongly agree

Medical History

Do you have a regular doctor you see for physicals and when you get sick? ☐ Yes ☐ No
If yes, who is your provider/agency?_____

Do you currently have any physical health problems? ☐ Yes ☐ No
If yes, please list them:

Are you currently taking any medication for a physical health condition? ☐ Yes ☐ No
If yes, please list the medication(s).

Mental Health Clinical History

Have you ever attended counseling for mental health concerns? ☐ Yes ☐ No
If yes, who is/was your provider/agency?_____

Have you ever taken a prescription medication for mental health concerns? ☐ Yes ☐ No
If yes, please list the medication (s).

Have you ever been hospitalized for mental health concerns?

☐ Yes ☐ No

Have you ever purposely injured yourself without suicidal intent (e.g. cutting, hitting, burning, etc)?

☐ Yes ☐ No

Do you have SERIOUS concerns or preoccupation with your body image, weight, exercise or what you eat?

☐ Yes ☐ No

Have you ever had strange experiences, such as hearing voices or seeing things that others do not see or hear?

☐ Yes ☐ No

Have you ever seriously considered attempting suicide?

☐ Yes ☐ No

Have you ever made a suicide attempt?

☐ Yes ☐ No

Have you ever intentionally caused serious physical injury to another?

☐ Yes ☐ No

Substance Use and Addiction Clinical History

Have you ever felt the need to reduce your alcohol or drug use? ☐ Yes ☐ No

Have others ever expressed concern about your alcohol or drug use? ☐ Yes ☐ No

Have you ever received treatment for alcohol or drug use? ☐ Yes ☐ No

How many times in the past two weeks have you had four or more alcoholic drinks in a sitting?

☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times

How many times in the past month have you used other drugs (e.g. weed, coke, acid, JUUL, ecstasy, pills)?

☐ Never ☐ 1 time ☐ 2-3 times ☐ 4-5 times ☐ More than 5 times

Do you have concerns about any of the following?

Gambling. ☐ Yes ☐ No

Pornography. ☐ Yes ☐ No

Time on screens/computers/Internet. ☐ Yes ☐ No

Sexual activity. ☐ Yes ☐ No

Trauma History

Has someone ever had sexual contact with you without your consent (e.g. you were afraid to stop what was happening, passed out, drugged, drunk, incapacitated, asleep, threatened or physically forced)?

☐ Yes ☐ No

Have you ever experienced harassing, controlling, and/or abusive behavior from another person (e.g. friend, family member, partner, or authority figure)?

☐ Yes ☐ No

Have you ever experienced a traumatic event that caused you to feel intense fear, helplessness, or horror?

☐ Yes ☐ No

If yes, please feel free to identify the type of traumatic event(s) here or if you prefer, talk with your clinician during your appointment.

Adverse Childhood Experiences

Please mark yes to any of the following questions that you experienced prior to your 18th birthday.

Did you feel that you didn't have enough to eat, had to wear dirty clothes, or had no one to protect or take care of you?

☐ Yes ☐ No

Did you lose a parent through divorce, abandonment, death, or other reason?

☐ Yes ☐ No

Did you live with anyone who was depressed, mentally ill, or attempted suicide?

☐ Yes ☐ No

Did you live with anyone who had a problem with drinking or using drugs, including prescription drugs?

☐ Yes ☐ No

Did your parents or adults in your home ever hit, punch, beat, or threaten to harm each other?

☐ Yes ☐ No

Did you live with anyone who went to jail or prison?

☐ Yes ☐ No

Did a parent or adult in your home ever swear at you, insult you, or put you down?

☐ Yes ☐ No

Did a parent or adult in your home ever hit, beat, kick, or physically hurt you in any way?

☐ Yes ☐ No

Did you feel that no one in your family loved you or thought you were special?

☐ Yes ☐ No

Did you experience unwanted sexual contact (such as fondling or oral/anal/vaginal intercourse/penetration)?

☐ Yes ☐ No