

PATHS
Psychological and Therapeutic Healing Services, PLLC

Sport/Performance Intake Form

The following questions are asked so that we can best understand you or your child. Please fill out this questionnaire before your intake appointment. Please read the questions carefully and answer them as fully as possible. Use extra paper if necessary. Thank you.

Identifying Information

Legal Name: _____ Preferred name: _____

Date of Birth: _____ Age: _____ Sport(s)/Performance Area: _____

Sex: Male Female Non-binary Preferred Pronouns: _____

Race: African American Asian Caucasian Hispanic Native American

Other: _____

Country of Origin: _____ How long have you been in the U.S. _____

Home Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

College Address: _____

City: _____ State: _____ Zip: _____ Phone: _____

Is it okay to leave a voicemail or text message at this phone number? Yes No

Email Address: _____

Contact Person in case of emergency: _____

Phone: _____ Relationship to You: _____

Primary Care Physician: _____ Phone: _____

Coach's name: _____

Does your coach know you are working with a sport/performance consultant? Yes No

Have you worked with a sport/performance consultant in the past? Yes No - If yes,

please check all that apply: Individually Team One-time session or seminar.

Referred by: _____

Reason for Seeking Services/ What are you hoping to accomplish by meeting with a sport/
performance consultant?:

When did you first notice difficulties?

Previous attempts to deal with problem and results: _____

Competitive Schedule:

Please take time to outline your upcoming competitive schedule. Please write the dates of the competition, the location, and rank the importance (1 = not that important to 5 = extremely important)

Dates	Location	Importance (1-5)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Practice Schedule:

Please take time to tell me about your weekly practice schedule. Please discuss when you usually practice, as well as when you do anything else related to your sport on a consistent basis (e.g., strength training).

Day of the Week	Location	Time
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Are you okay with me attending practices? ____ Yes ____ No; If yes, do you want me to notify you before I attend? ____ Yes ____ No

Prior problems/legal: _____

Recent life stressors? ____ Yes ____ No (if yes, please specify): _____

Past Psychiatric Treatment History

Outpatient Counseling/Therapy (If yes, when and where): _____

Inpatient Treatment (If yes, when, where, and for how long): _____

Current psychiatric Medication: _____

Prescribing physician: _____

Family History:

Biological Mother: _____ Age: _____ (If deceased, what year and how old were you. Education: _____ Occupation: _____

Please briefly describe your biological mother: _____

Biological Father: _____ Age: _____ If deceased, what year and how old were you. Education: _____ Occupation: _____

Please briefly describe your biological father: _____

Did your parents divorce? ____ Yes ____ No; If yes, how old were you? _____

Who did you live with after the divorce? _____ Who was in your house growing up? _____

Medical Information

At times, medical issues can impact sport performance. Please review the below questions and respond to any that you feel might be helpful for your work with a sport/performance consultant.

Medical problems/physical concerns (e.g., high blood pressure, headaches, stomachs, etc):

What medications are you taking at present, including vitamins and nutritional supplements, and for what purposes? _____

History of head trauma: _____

Menstrual cycle (if applicable): ___ regular ___ irregular ___ birth control: _____

Sleep difficulties: ___ falling/staying asleep ___ nightmares ___ restless ___ by self
___ wets bed ___ hard to wake _____ Typical bed time _____ Time to get to sleep

Appetite: ___ average ___ picky ___ poor ___ recent decrease ___ recent increase

Eating habits: _____

School History

College Attending & Year (e.g., Freshman, Sophomore, etc): _____

Did you transfer from another college/university? _____

Did you ever repeated a grade? If yes, which one _____

Current grades: _____

Recent change in grades? ___ Yes ___ No; Explain: _____

Have you ever been tested for learning disabilities, IQ, etc? _____

Tutoring: _____

Social History

Substances Use: ___ Yes ___ No Age of first use: _____

Employment: _____ Hours work per week: _____

Housing - Number of roommates: _____ Do you get along with your roommates? ___ Yes ___ No

If no, please explain: _____

Do you feel you have enough friends? ___ Yes ___ No

Describe your current friends and activities with friends: _____

Symptoms and Behaviors

Sometimes other areas of your life can impact your sport performance. Take time to review the below symptoms and check each item that currently concerns you:

What Brings You in Now? Please rate the importance to you of each of the following issues.

What is your level of interest in working on this issue? Please **circle** your choice.

0 = "No Importance" to 3 = "Of Highest Importance"

	<u>N/A</u>	<u>Low</u>	<u>High</u>
Competition anxiety.....	0	1	2.....3
Acculturation.....	0	1	2.....3
Difficulty with training demands, overtraining.....	0	1	2.....3
Difficulty with elite athlete lifestyle demands.....	0	1	2.....3
Issues within team and/or with teammates.....	0	1	2.....3
Communication difficulties.....	0	1	2.....3
Motivation for sport, training.....	0	1	2.....3
Performance slump.....	0	1	2.....3
Media exposure.....	0	1	2.....3
Difficulty with travel demands.....	0	1	2.....3
Concentration training.....	0	1	2.....3
Goal Setting training.....	0	1	2.....3
Imagery, Visualization training.....	0	1	2.....3
Relaxation training.....	0	1	2.....3
Retirement from sport.....	0	1	2.....3
Sport confidence.....	0	1	2.....3
Schoolwork, grades.....	0	1	2.....3
Procrastination, time management.....	0	1	2.....3
Stress management.....	0	1	2.....3
Decisions about major/career.....	0	1	2.....3
Concern for welfare of another person.....	0	1	2.....3
Relationship with teammate(s).....	0	1	2.....3
Relationship with roommate(s).....	0	1	2.....3
Relationship with coach(es).....	0	1	2.....3
Relationship with romantic partner.....	0	1	2.....3
Relationship with parents, family.....	0	1	2.....3
Gay/lesbian/bisexual issues.....	0	1	2.....3
Shyness, being assertive.....	0	1	2.....3

Self-esteem, self-confidence.....	0	.....	1	.....	2	.....	3
Loneliness, homesickness.....	0	.....	1	.....	2	.....	3
Feeling down, sad, depressed.....	0	.....	1	.....	2	.....	3
Fears, worries, anxiety.....	0	.....	1	.....	2	.....	3
Irritable, angry, hostile feelings.....	0	.....	1	.....	2	.....	3
Injury, fear of injury.....	0	.....	1	.....	2	.....	3
Chronic physical problem (e.g., asthma).....	0	.....	1	.....	2	.....	3
Physical stress (headaches, stomach pains, muscle tension, etc.).....	0	.....	1	.....	2	.....	3
Sleep difficulties.....	0	.....	1	.....	2	.....	3
Eating/body image/weight issues.....	0	.....	1	.....	2	.....	3
Problems with alcohol or other substances.....	0	.....	1	.....	2	.....	3
Suicidal feelings or behavior.....	0	.....	1	.....	2	.....	3

Please note below any additional concerns or areas of interest you would like to focus on:

Please rate each of the following concerns as they apply to you at the **present time** on a scale of 1-5 (1 = not a problem/no concern; 3 = somewhat a concern/problem; 5 = very strong/severe concern).

Make the best estimate you can. Circle your response.

Feelings of sadness, crying, being "down"	1	2	3	4	5
My mind feels like its racing	1	2	3	4	5
Unwanted thoughts in my mind	1	2	3	4	5
Sometimes I can't control what I do	1	2	3	4	5
Sleep problems	1	2	3	4	5
Feeling worthless	1	2	3	4	5
Problems with anger/temper	1	2	3	4	5
Feeling like things aren't real	1	2	3	4	5
Problems with my eating	1	2	3	4	5
There are things too painful to talk about	1	2	3	4	5
Concerns about my sexuality	1	2	3	4	5
Use of alcohol and/or drugs	1	2	3	4	5
Doing things over and over	1	2	3	4	5
Seeing or hearing things that others don't	1	2	3	4	5
Feeling anxious/nervous	1	2	3	4	5

Being close to people	1	2	3	4	5
Spiritual concerns	1	2	3	4	5
Pain and/or health concerns	1	2	3	4	5

Is there any additional information you believe would be helpful for the sport/performance consultant to know?

Sport Rehabilitation

Are you involved in sport rehabilitation? ____ Yes ____ No Date of Injury: _____

Injury: _____

Are you currently in Physical Therapy? ____ Yes ____ No Name of PT: _____

About You:

What is your home country? _____

What is your experience moving to the USA? _____

What is your favorite book? _____

What is your favorite song or artist? _____

What is your favorite quote? _____

What is your personal philosophy/how do you view life? _____

What is your first sport memory? _____

What do you love about your sport? _____

Who inspires you? Why? _____

What has your sport taught you about life? _____

Confidentiality Statement

Information about you, including professional records that are required by the laws of AZ and the standards of my profession, will be kept strictly confidential. Please be aware of the following exceptions to the law:

1. If you present a danger to yourself or others, I have a legal requirement to help keep you safe and a duty to warn potential victims.
2. If you identify any known or suspected abuse of a child, an elder, or person with a disability, I am required by law to report such abuse to the appropriate state agency.
3. If ordered by a judge in a court of law, I am required to provide access to your records; however, I would first assert legal privilege in an effort to protect your confidentiality.

Further information regarding the protection of your confidentiality is found in the HIPPA compliance form.

Please ask any questions necessary regarding the limits of confidentiality. If you have no further questions, please sign below to indicate that you have read this statement as well as the HIPPA compliance form and understand the contents.

Client Name (please print)

Date

Client Signature

(Sport Psychology Consultant Signature)