New Client Questionnaire: Sports Excellence & Psychology

This questionnaire is designed to help your providers understand more about you. The primary purpose of asking these questions is to develop a treatment plan that will best suit your sport-related goals. By completing these questions as completely and honestly as you can, we will be able to offer you care in alignment with your performance. We are education-focus based on the latest research in sport psychology/performance. Our goal is to assist you in reaching your optimal level of performance, in some cases, return to sport/adapting to life post injury. We work collaboratively with your medical team as part of a comprehensive multi-disciplinary team.

<table>
<tr><td colspan="3">Who referred you to us:_____</td><td colspan="2">Date</td></tr>
<tr><td colspan="2">First Name:</td><td>MI:</td><td colspan="2">Last Name:</td></tr>
<tr><td>Birthdate:</td><td>Age:</td><td>Gender:</td><td colspan="2">Email:</td></tr>
<tr><td>Local Mailing Address:</td><td colspan="2">Home Phone:

Work Phone:

Pager or Cell phone:</td><td colspan="2">Ethnic Group (please circle one):
American Indian or Alaskan Origin
White, Not of Hispanic Origin
Latino or Hispanic Origin
Black, Not of Hispanic Origin
Asian or Pacific Islander
Other:_____</td></tr>
<tr><td colspan="3">Occupation/Education Status (If in school, what grade/year)</td><td colspan="2">Education (School, Degree, GPA -if in HS)</td></tr>
<tr><td colspan="3">Level of occupational/school stress: (0-10) “0” no stress/”10” most stress
0 1 2 3 4 5 6 7 8 9 10</td><td colspan="2">Name of Educational Institution:</td></tr>
<tr><td colspan="3">Marital Status (please circle one) Single Dating Engaged
Married Separated Divorced Widowed
Living with a partner</td><td colspan="2">Length of time in current relationship:</td></tr>
<tr><td colspan="3">Spouse/Significant other’s first name:</td><td colspan="2">Person who understands you:
most as an athlete:

Least as an athlete:</td></tr>
<tr><td colspan="5">Have you worked with a sport psychologist before? No If yes, who:

If yes, was it helpful:</td></tr>
<tr><td colspan="5">What is/are your sports, position(s) and coaches’ names?

Fall: Position(s): Coach:

Winter: Position(s): Coach:

Spring: Position(s): Coach:</td></tr>
<tr><td colspan="5">What is your primary sport/position:</td></tr>
<tr><td colspan="5">What are you hoping to accomplish meeting with a sports excellence coach? What is missing in your performance?</td></tr>
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What is your current training/practice schedule?

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Are you ok with me attending a practice? Yes or No

Sports Excellence

MENTAL PREPARATION

Do you engage in any pre-competition mental preparation to enhance performance? No Yes: _____

_____

What is your favorite book_____

What is your favorite artist(s)/song(s)_____

_____

What is your favorite quote/saying/motto_____

_____

What is your personal philosophy_____

What is your first sport memory_____

What do you love about your sport(s)_____

_____

What or Who inspires you and why_____

_____

What has your sport taught you about life_____

_____

What is your ultimate sport goal/fantasy _____

_____

Do you keep any type of training log to track progress/goals _____

_____

Sometimes other areas of life can impact athletic performance. Please review the following and endorse those that may affect your attention/performance:

	Academic Performance		Difficulty getting along with teammates
	Athletic Performance		Difficulty getting along with coaches
	Negative Body Image		Difficulty with social situations
	Low Self-Esteem		Phobias/Fears
	Mood Swings		Loneliness
	Panic Attacks/Anxiety		Grief/Loss
	Recurring Thoughts		Memory Problems
	Impulsiveness		Legal Problems
	Hopelessness or Depression		Fatigue
	Anger/Aggression/Easily Irritable		Family Problems
	Elevated mood, easily excited		Substance misuse (non prescribed)
	Racial or ethnic issues		Alcohol misuse
	Coping with prejudice		Abuse: Emotional, Physical or Sexual
	Shyness around others		Self-Harm (cutting, etc.)
	Eating Issues		Sexual Identity/Orientation

Please rank order the top 4 symptoms checked above by priority and severity: (#1 most pressing concern, #2 moderately pressing concern, etc. to lesser extent)

1. **4.**

2. **5.**

After a team/individual loss or disappointing athletic performance, how are you affected and how long do you stay negatively affected? What do you do to recollect your focus?

Is there any additional information about your mental functioning you believe to be relevant to your athletic performance, positive or negative:

PHYSICAL PREPARATION

At times, medical issues can impact sports performance. Please review the questions below and respond with honesty and openness:

How many hours do you sleep per night, on average:

Sunday	Monday	Tuesday	Wednesday	Thursday	Friday	Saturday

Do you have any problems sleeping: Falling Asleep Staying Asleep Early Morning Awakening

Comments: _____

What would you rate your average level of energy on a daily basis:
Great Rarely Tired/Fatigued Sometimes Tired/Fatigued Often Tired/Fatigue Always Tired

If "often" or "always," how long has this been going on?_____

MEDICAL HISTORY

Are you currently seeing a physician for a medical condition? No or yes: _____

_____

Are you currently seeing a physical therapist (PT) for treatment? No or yes: _____

_____

INJURY HISTORY

Date	Injury	Duration	Treatment	Comments

Do you consider yourself injury prone? No Yes, Comments: _____

_____

When injured, do you consider yourself: Resilient or Devastated? Comments: _____

_____

MEDICAL CONDITIONS

Please check the medical problems/conditions or treatments that **apply to you now or in the past.**

	Diabetes		Problems digesting food		Tuberculosis
	Asthma		Irritable bowel syndrome		Mononucleosis
	Other breathing problems		Headaches		Urinary problems
	Anemia (low iron or ferritin)		Cystic Fibrosis		AIDS or HIV positive
	Vitamin D deficiency		Cancer		Sickle Cell Disease
	High Blood Pressure		Seizures		Other:
	Irregular Heart Beat		Other:		Other:

PHYSICAL SYMPTOMS

Please check the physical symptoms that have been a problem for you over the past month, if uniquely in performance put "P"

	Dry mouth		Tics/Twitches		Fainting or dizzy spells
	Constipation		Chest pain		Swollen ankles
	Fatigue		Chills/Hot flashes		Trembling/Shaking
	Choking sensation		Urinary problems		Changes in hearing or vision
	Stomach problems		Constant pain		Fainting or dizzy spells
	Nausea		Muscle tension		Blackouts
	Diarrhea		Difficulty urinating		Unexplained weight loss
	Headaches		Shortness of breath		Unexplained weight gain
	Sweating		Other:		Other:

MEDICATION

Please list any medications you are currently taking or have taken within the last year (include vitamins, laxatives, birth control pills or alternative or herbal medicines)

Medication	Dosage	Date Began	Date Ended (if applicable)	For What

ALLERGIES

Are you allergic to any medications? YES NO Are you allergic to any foods? YES NO

If YES to either of the above, please give details.

Substance:	Response:
Substance:	Response:
Substance:	Response:
Substance:	Response:

NUTRITIONAL STATUS

What is your current weight: _____ Highest in past year: _____ Lowest in past year: _____

Have you gained or lost more than 15 pounds in the past year? No or if Yes: _____

_____

If you have gained weight, has it impacted your performance? No If yes: Better or Worse
Explain: _____

Are you satisfied with your current weight? Yes or No: _____

_____

How many meals per day do you typically eat? Breakfast Lunch Dinner

What is a Typical Meal

Breakfast	Lunch	Dinner

Most frequent snacks: _____

_____

How many days per week do you eat fast food? _____/Where do you eat: _____

Do you have any dietary restrictions and/or food preferences _____

_____

Hydration

Approximately how much water do you consume on a daily basis?

Total servings (8 ounces/1 cup): _____ General comments: _____
Do you consume energy drinks or coffee prior to competition? No or Yes

_____

Do you hydrate differently for competition? Please describe: _____

_____

What questions about sports nutrition do you have? _____

_____

Have you experienced:	**Currently** (in the last week)	**Recently** (in the last 6 months)	**Previously** (over 6 months ago)	**Never**
Been told by a coach or other person to lose weight				
Been told by a coach or other person to gain weight				
Taken over the counter weight loss products				
Participated in formal weight loss program (i.e. Weight Watchers, Jenny Craig, Nutrisystem)				
Independently followed a weight loss program (i.e. Atkins, South Beach Diet, etc.)				
Seen a registered dietician (RD)				
Received individual counseling for weight loss				
Received individual counseling for weight gain				
Independently/followed a weight-gain program				
Used a journal/nutrition log to track progress				
Been diagnosed with an eating disorder by a medical professional				
Felt like food was controlling your life				
Restricted caloric intake to below 1000 calories per day				
Used diuretics (water loss pills) or laxatives (pills, tea)				
Binged on food (consumed over 800 calories in a sitting)				
Purposefully made yourself vomit (purged)				

RELAXATION AND LIFE BALANCE

Do you include any as part of your training	**Currently** (in the last week)	**Recently** (in the last 6 months)	**Previously** (over 6 months ago)	**Never**
Diaphragmatic Breathing				
Meditation				
Visualization and Imagery				
Positive Self-Talk/Use of “power words”				
Yoga or Pilates				
Utilizing Apps for performance enhancement				
Watching motivation videos (i.e. You Tube, Ted Talks)				
Studying professional athletes’ work ethic/training				
Other:				
Other:				

POSITIVE COPING SKILLS

On any given day, we have a bad day or may feel lousy, have a fight with someone, be under pressure academically or to perform. What are your top three coping skills

MENTAL HEALTH HISTORY

Please check any of the following that apply regarding present or past treatment

	Currently or previously seen a psychiatrist? Prescribing MD
	Currently or previously seen a therapist for individual counseling
	Currently or previously seen a family counseling
	Currently or previously seen a pain management physician
	Currently or previously seen a physician for addiction treatment

Current mental health diagnosis(es);

If you are currently under the care of a counseling professional, would you like them to be a part of your sports excellence team?

Yes or No Comments: _____

FAMILY MENTAL HEALTH HISTORY

Please check the mental health conditions or treatments that apply to any members of your family. Please enter the appropriate letter(s) to indicate which family member after the condition (M=Mother, F=Father, S=Sister, B=Brother, A=Aunt, U=Uncle, GP=Grandparents.

	Attention Deficit Hyperactivity Disorder or Attention Deficit Disorder		Learning Disability		Mental Retardation
	Psychosis (such as schizophrenia)		Bipolar Disorder or Manic Depressive Illness		Depression
	Anxiety Disorder (such as panic disorder, phobia, or very excessive worry)		Alcohol or Drug Abuse		Hospitalized for Mental Health Problem

PSYCHOSOCIAL HISTORY

Family/Life History (there is often a correlation between significant life events and eating patterns)

Please check any of the following events that applied to you as a child, adolescent or adult:

	Happy Childhood		Abusive Relationship
	Unhappy Childhood		Rape
	Death of parent		Miscarriage
	Death of someone close		Abortion
	Filed for bankruptcy		Crime victim
	War/ As a citizen or active duty service member		Natural disaster
	Poverty		Been diagnosed with PTSD

Learning/Education

In general, do you like school? Yes No Comment: _____

If college level, what is your major? _____

Are you on any type of scholarship? Academic Athletic (partial full)

In high school, do you have a major of interest_____

Do you want to play sports in college? If so, which one(s) _____
D-1 D-2 D-3 Any college opportunity
Do you anticipate receiving an athletic scholarship No Yes

Current GPA (if in school)		
Subjects and Grades		
English	Science	Other
Math	Foreign language	Other
History	Other	Other

Please check any of the following that applied to you during your education (grade school, high school, and/or college)

	Bullied about weight/appearance		Being involved in my activities		Being suspended or expelled
	Low grades		Being held back a grade		Few friends
	High grades		Skipping ahead a grade		Truancy
	Introverted personality		Too many clicks, didn't fit in		Bad social situation didn't pass
	Other:		Other:		Other:
	Other:		Other:		Other:

Alcohol Use

Please check any of the following that apply to you:	YES	NO
Do you drink alcohol now or have you in the past (including beer and wine)? If yes, please answer the following:		
• Has your alcohol use increased in the past month?		
• Have you had problems in your relationships with friends or family due to alcohol use?		
• Have you had problems at work or at home due to alcohol use?		
• Have you blacked out in the past from drinking alcohol?		
• Have you ever been in treatment for over use of alcohol (including AA, Rational Recovery, etc.)?		
• Have you had trouble with the law due to alcohol use (i.e. DUI, drinking underage, public intoxication, alcohol-related violence)?		
• Do you drive after drinking alcohol?		
• How many drinks to get a "buzz"?		
• How many drinks to feel drunk?		

Other Substances

Please check any of the following that apply to you:	YES	NO
Do you use tobacco products? If yes, please answer the following		
• Kind: Amount per day?		
• Began use at what age?		
Do you drink caffeinated beverages? If yes, please answer the following		
• Kind: Amount per day?		
• Kind: Amount per day?		

Have you ever MIS used:	**Currently** (in the last week)	**Recently** (in the last 6 months)	**Previously** (over 6 months ago)	**Never**
Performance Enhancement (PE) (steroids)				
Over the Counter PE (creatine, amino acids, glutamate)				
Bronchial dilator (asthma inhaler)				
Cannabis, THC, marijuana, hashish				
Benzodiazepines (anti anxiety): Valium, Ativan				
Sleeping pills: Ambien, Restoril				
Stimulants: Cocaine/amphetamines				
Opioids: Oxycontin, Percocet, Vicodin, Demerol				
Heroin				
Club drugs: GHB, Ecstacy				
Inhalents (glue, paint, aerosol cans, etc.)				
By prescription: ADHD medications (Ritalin, Concerta)				
ADHD medications NOT by prescription				
Other:				
Other:				
Other:				

Have you ever been prescribed narcotic pain medication post injury? No Yes_____

_____

_____

Religion/Spirituality (Adapted from Strayhorn's Religiousness Scale, 1990) Please circle the answer that applies

When you make decisions in your everyday life, how often do you ask God for help with the decisions? 1. never 2. seldom 3. sometimes 4. often 5. very often
To what extent is the direction of your life influenced by some religious goal or purpose? 1. not at all 2. to a small extent 3. to a moderate extent 4. to a large extent 5. to a very large extent
What is your Religious Denomination?

LEADERSHIP AND TEAM COMMITMENT

(Assessment forms provided at intake appointment, as applicable)

GOALS FOR TREATMENT

1. _____

2. _____

3. _____

What percentage of confidence (0 – 100%) do you have that you can help yourself reach these goals *without* any assistance?

0%	10	20	30	40	50	60	70	80	90……100%
Not at all Confident									Totally Confident

What percentage of confidence (0 – 100%) do you have that you can help yourself reach these goals *with* assistance?

0%	10	20	30	40	50	60	70	80	90……100%
Not at all Confident									Totally Confident

Thank you for completing this portion of the assessment.

Signature: _____ **Date** _____

Thank you,

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