RISE CENTER FOR PEAK PERFORMANCE

# NEW CLIENT FORM

**DATE:** _____

1) **CLIENT:**

NAME: _____ AGE: _____ BIRTHDATE: _____

ADDRESS: _____ CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL PHONE: _____ EMAIL: _____

2) **FOR CLIENTS UNDER AGE 18:**

MOTHER'S NAME: _____ AGE: _____ FATHER'S NAME: _____ AGE: _____

ADDRESS: _____

CITY: _____ STATE: _____ ZIP: _____

HOME PHONE: _____ CELL: (m) _____ (d) _____

EMAIL: (m) _____ (d) _____

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MARITAL STATUS OF PARENTS: (Circle One) Married Separated **Divorced*** Widowed

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***If Divorced:** Custody: _____

Visitation: _____

Child's Main Residence: _____

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3) **DOES THE CLIENT HAVE A HISTORY OF, OR IS THERE ANY FAMILY HISTORY OF THE FOLLOWING? (PLEASE NOTE RELATIONSHIP TO THE CLIENT IF THERE IS A FAMILY HISTORY):**

DEPRESSION: ☐YES ☐NO _____
BIPOLAR DISORDER OR MANIC-DEPRESSION: ☐YES ☐NO _____
ANXIETY: ☐YES ☐NO _____
ADHD: ☐YES ☐NO _____
AUTISM: ☐YES ☐NO _____
DEVELOPMENTAL DELAYS: ☐YES ☐NO _____
SELF-INJURY: ☐YES ☐NO _____
ATTEMPTED/COMPLETED SUICIDE: ☐YES ☐NO _____
ALCOHOLISM/SUBSTANCE ABUSE: ☐YES ☐NO _____
LEARNING DISABILITIES: ☐YES ☐NO _____
PSYCHIATRIC HOSPITALIZATION: ☐YES ☐NO _____
HEAD INJURY/CONCUSSIONS: ☐YES ☐NO _____
HEART PROBLEMS: ☐YES ☐NO _____
DIABETES: ☐YES ☐NO _____
SEIZURE: ☐YES ☐NO _____
ALLERGIES: ☐YES ☐NO _____

**a)** OTHER THERAPIST OR OTHER MENTAL HEALTH PROVIDER:
*May I contact this person for the purposes of treatment coordination?* □ YES □NO

NAME: _____ OFFICE PHONE:_____

**b)** PRIMARY CARE PHYSICIAN/PEDIATRICIAN:
*May I contact this person for the purposes of treatment coordination?* □ YES □NO

NAME:_____ OFFICE PHONE:_____

**4) CURRENT MEDICATIONS/SUPPLEMENTS/VITAMINS: (Please continue on reverse as needed)**

| MEDICATION NAME | DOSAGE | SCHEDULE (e.g AM, PM) | REASON |
|---|---|---|---|
| | | | |
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**5) CURRENT SCHOOL IF APPLICABLE:**

SCHOOL: _____ GRADE: _____

IS THERE A 504 PLAN IN PLACE? YES □ NO □ IS THERE AN IEP IN PLACE? YES □ NO □

HAS PSYCHOLOGICAL OR PSYCHOEDUCATIONAL TESTING EVER BEEN ADMINISTERED? YES □ NO □

IF IN HIGH SCHOOL, DO YOU CURRENTLY HAVE A COLLEGE COUNSELOR? YES □ NO □

**6) ATHLETIC HISTORY:**

SPORT(S) FOR WHICH YOU ARE SEEKING SERVICES? _____
NUMBER OF YEARS TOTAL PLAYING THIS SPORT: _____
WHAT ARE YOUR GOALS IN YOUR SPORT?
• SHORT TERM _____
• LONG TERM _____
HAVE YOU WORKED WITH A SPORT PSYCHOLOGIST IN THE PAST?_____(Y)_____(N)
HAVE YOU EVER INCLUDED SPORT PSYCHOLOGY INTO YOUR SPORT PREPARATION? _____(Y)_____(N)
WHAT BRINGS YOU IN NOW, AND WHAT ARE YOU HOPING TO ACCOMPLISH BY MEETING WITH ME? _____

Please rate the **importance to you of learning about or working with** each of the following issues:

| | None | Low | Moderate | High |
|---|---|---|---|---|
| Competition anxiety | 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 (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: _____

_____

_____

_____

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**7) HOW DID YOU HEAR OF MY PRACTICE?**

REFERRAL SOURCE: _____