Fishbein & Associates
Performance Consulting

New Client Information

1) CLIENT:

Name: _____ Age: _____ Birthdate: _____

Address: _____ City: _____ State: _____ Zip: _____

Cell Phone: _____ Email: _____

2) FOR CLIENTS UNDER AGE 18:

Mother's Name: _____ Cell: _____ Email: _____

Father's Name: _____ Cell: _____ Email: _____

Address: _____ City: _____ State: _____ Zip: _____

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):

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 _____

4) OTHER PROVIDERS:

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

NAME: _____ OFFICE PHONE: _____

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

NAME: _____ OFFICE PHONE: _____

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

MEDICATION NAME	DOSAGE	SCHEDULE (e.g AM, PM)	REASON

6) 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 ☐

7) SPORTS:

Sport(s) for which you are seeking services? _____

What are your short and long term goals in your sport? _____

Have you worked with a sport psychologist in the past?_____(Y)_____(N)

What brings you in now, and what are you hoping to accomplish by meeting with us? _____

_____

_____

8) AREAS TO ADDRESS:

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

	None	Low	Mod.	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
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
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
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
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

9) **REFERRAL SOURCE:** _____