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**ATHLETES – Confidential Intake Questionnaire**

*These questions are intended to help me understand what you hope to gain from working with me, and some general information about your overall wellbeing and history. Questions can be answered by the athlete or parent based on your best judgement. You are not obligated to answer every question; please skip any item that makes you uncomfortable. You can email the completed forms to* [*DanielMZimet@gmail.com*](mailto:DanielMZimet@gmail.com) *with the understanding that email is not a confidential form of communication, or provide me with a hardcopy.*

Name:       Date of first appt:       Birth date:

Address:

Age:       Sex at birth:       Preferred gender:

Phone #:       Email:       Preferred means of contact:

Employment/Education situation:

For athletes who are minors:

Parent1 Phone #:       Preferred means of contact:

Parent2 Phone #:       Primary contact: Parent1 ; Parent2

Preferred Email (for invoicing):

**About your appointment:**

How did you learn about me/my practice?

If applicable, is it okay for me to thank whomever referred you to me? Yes ; No

Why have you scheduled this appointment?

What are you hoping to accomplish during our work together?

What do you see as your greatest strengths/assets as an athlete?

In what areas are you hoping to see growth/improvement?

**Current and prior treatment:**

Are you currently prescribed psychiatric medication? Yes ; No

If you have been diagnosed with a mental health condition, please identify what it is and when you were first diagnosed:

If you have a close, biological family member with mental illness, who is it, and what is the diagnosis?

**General health questions (Optional):**

Current competitive schedule: identify the sport(s), organization(s), and team(s):

How would you describe the team atmosphere of your current athletic program(s):

Are you experiencing any injuries/medical concerns?

Please take a moment to let me know more about you as a whole person (including but also beyond athletics), such as your interests, accomplishments, skills, future ambitions, and enjoyed activities:

**Please identify those areas which are a concern for you (otherwise leave blank):**

|  |  |
| --- | --- |
| Mood concerns:  Depression (sadness):  Anxiety (worry):  Panic attacks or fearfulness:  Quickly changing moods:  Easily irritated/short-fused:  Life feels meaningless:  No future goals or ambitions:  Few interests or hobbies:  History of suicide attempt(s):  Currently suicidal ideation: | Social/relationship concerns:  Loneliness/isolated:  Few friends:  Poor social skills:  Relationship problems:  Marriage problems:  Parenting problems:  Death of family member:  Conflict with family:  Parents divorced/separated: |
| Physical concerns:  General health concerns:  Low energy/tired:  Chronic health condition:  Chronic pain:  Difficulty sleeping:  Problems with weight:  Poor eating habits:  Lack of exercise:  Self-harm (cut/burn self): | Cognitive/executive functioning concerns:  History of concussions:  History of brain trauma:  Procrastination:  Poor concentration/attention:  Disorganized:  Trouble thinking clearly:  Bizarre/frightening thoughts: |
| Work/educational concerns  Work problems/dissatisfaction:  Current workplace abuse:  Under or unemployed:  Financial problems:  Learning challenges:  Current legal problems:  Prior arrest/felony charges:  Dependent – Insufficient autonomy: | Other concerns:  History of drug/alcohol abuse:  Current drug/alcohol abuse:  Addiction to pornography:  Addiction to gaming:  Childhood emotional abuse:  Childhood physical/sexual abuse:  Caretaker of s/o with chronic illness:  Lacking assertiveness skills:  Anger management problems: |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Patient Health Questionnaire PHQ-9  Over the last two weeks how often have you been bothered by any of the following problems? | | | | |
|  | Not at all | Several days | More than half the days | Nearly every day |
| Little interest or pleasure in doing things |  |  |  |  |
| Feeling down, depressed, or hopeless |  |  |  |  |
| Trouble falling/staying asleep, sleeping too much |  |  |  |  |
| Feeling tired or having little energy |  |  |  |  |
| Poor appetite or overeating |  |  |  |  |
| Feeling bad about yourself, or that you are a failure, or have let yourself or your family down |  |  |  |  |
| Trouble concentrating on things, such as reading the newspaper or watching TV |  |  |  |  |
| Moving or speaking so slowly that other people could have noticed. Or the opposite; being so fidgety or restless that you have been moving around more than usual |  |  |  |  |
| Thoughts that you would be better off dead or of hurting yourself in some way |  |  |  |  |
| Anxiety GAD-7  Over the last two weeks how often have you been bothered by any of the following problems? | | | | |
|  | Not at all | Several days | More than half the days | Nearly every day |
| Feeling nervous, anxious or on edge |  |  |  |  |
| Not being able to stop or control worrying |  |  |  |  |
| Worrying too much about different things |  |  |  |  |
| Trouble relaxing |  |  |  |  |
| Being so restless that is hard to sit still |  |  |  |  |
| Becoming easily annoyed or irritable |  |  |  |  |
| Feeling afraid as if something awful might happen |  |  |  |  |

If you checked off any problem on this questionnaire, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?

Not difficult at all; Somewhat difficult; Very difficult; Extremely difficult

*Thank you for taking the time to answer these questions. I look forward to discussing your responses when we meet.*