



KENYA ACADEMY OF SPORTS
Beyond sporting talent

ATHLETE MENTAL HEALTH EXAMINATION FORM

(To be completed by the athlete or parent/guardian in the presence of a certified Mental Health Specialist)

Name: _____ Sport: _____

Date: _____ D.O.B.: _____ Age: _____

Address: _____

County: _____

Phone number(s): _____

E-mail address: _____

Describe briefly your family (those whom you live with):

Relationship

Age

How do you get along?

Sport Psychology History

Have you ever included sport psychology into your sport preparation? ___Y___N

Have you worked with a sport psychologist or psychologist before? ___Y___N

If yes, please explain: _____

Please describe your background/experience in your sport discipline: _____

Please rate each of the following issues as they relate to you:

	N/A	Low	Medium	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
Procrastination, time management.....	0	1	2	3
Stress management.....	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
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 issues.....	0	1	2	3
Body image/weight issues.....	0	1	2	3
Problems with alcohol or other substances.....	0	1	2	3
Any form of abuse/harassment encountered.....	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	
Feeling rejected	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	
Seeing or hearing things that others don't	1	2	3	4	5	
Do you experience nightmares	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	

Have you sustained any injuries in your sport(s)? Y or N

Are you currently taking any medications or are you under any other type of treatment? Y or N

Medication/Treatment Dates Prescribing Physician

Have you ever been hospitalized for mental health reasons? Y or N

If so please provide the following information to the best of your ability:

Hospital Name Dates Reason Medications prescribed

Have you experienced any trauma? Y or N

If yes, please provide the details: _____

Confidentiality Statement

Information about you, including professional records that are required by the laws of the State 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 other KAS policies.

_____ Athlete's Name	_____ Date	_____ Signature
_____ Parent/Guardian Name	_____ Date:	_____ Signature
_____ Certified Mental Health Specialist	_____ Date:	_____ Signature

Consent to Consultation

I have read and discussed both the Confidentiality Statement and the Notice of Mental Health related policies and Practices to Protect the Privacy of Your Health Information. I have been given a copy of the Notice. I have also discussed the Mental Health Consultation Information Sheet. I am willingly consenting to abide with the parameters stated in those documents.

_____ Client Name (please print)	_____ Date
_____ Client Signature	_____ (Mental Health Consultant Signature)

Parental Release in case of a minor

I agree _____ do not agree _____ to have _____ (Mental Health Consultant Name) work with my son/daughter on issues related to performance enhancement. I agree _____ do not agree _____ that there will be a confidential relationship during the performance enhancement work and trust to inform me of any important developments as it relates to my son /daughter.

_____ Parent/Guardian Signature	_____ (Sport Psychology Consultant Signature)
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Additional Issues that Need to be Addressed:
