St.Vincent Sports Performance Center

Patient Registration Information

General Information

First Name:_________________________Middle:___________________Last Name:________________

Address:________________________________City:_______________State:_________Zip:_________

Home Phone:_____________________SSN#_____________________Sex: ( ) Male ( ) Female

DOB:_______________ Age:_________Referred by:____

Cell Phone:_______________________ Email Address:_________________________________

Marital Status: [ ] Single [ ] Separated [ ] Divorced [ ] Married [ ] Widowed

Ethnic/Cultural Background (optional) _________________________________

Height:______________ Weight:___________________

Patient lives: Alone with no assistance With parents With spouse or partner Other:

Were you injured while working/worker's comp? [ ] NO [ ] YES Date of Injury:_______
Are you represented by and attorney? [ ] NO [ ] YES Attorney Name:______
Are you here on an emergency basis? [ ] NO [ ] YES

Vocational Status:
[ ] Full time student [ ] Part time student [ ] Homemaker [ ] Retired [ ] disabled
[ ] Part time employed [ ] Limited employment [ ] Unemployed [ ] Full time employed

Occupation:
Employer:____
Work Phone:____

Emergency Contact information

Name:_______________________________________ Phone:__________________________

Relationship:____

Referral Information

Who referred you to for services/How did you hear about the clinic?

____

Address of referral source:____

Phone number of referral source: _________________ Fax number: ___________________

If you **DO NOT want us to send a copy of our report to the referral source, please mark here

Insurance Information

Are you covered by insurance health plan(s) [ ] YES [ ] NO

If yes we need to make a copy of your insurance card(s).

Primary Insurance:_______________________
Name of Insured:_________________________
Relationship to Patient:___________________
Insured DOB:________ Sex [ ] Male [ ] Female

Secondary Insurance:______________________
Name of Insured:_________________________
Relationship to Patient:___________________
Insured DOB:_______ Sex: [ ] Male [ ] Female

Responsible Party, if other than Patient: (Person responsible for Payment of all costs incurred)

First Name:______________________Middle:____________Last Name:_______________________

Responsible party's relationship to patient: [ ] Spouse [ ] Child [ ] Parent [ ] Other:_____

FINANCIAL CONSENT FORM

The Department of Sport and Performance Psychology is committed to supporting our health care needs. It is our goal to provide you with excellent service. If you have any questions and/or problems during your visit, pleas feel free to ask any of our employees for assistance.

Authorization Statement:
Permission in herby granted to the psychologist and/or professional staff of the department of sport and performance psychology, acting under the supervision of a licensed psychologist, to administer such treatment and examination as deemed necessary for myself or the patient name don this registration. I understand that no partner or associate of St. Vincent Hospital will provide services beyond the scope of their training, certification, and licensure.

By signing my name below:
I herby guarantee payment in full within thirty 930) days of all charges established by St. Vincent Health for services rendered to me, unless other arrangement satisfactory to St. Vincent Health have been made. This includes any charges that a third party payer may determine to exceed usual and customary limits.

I understand that If I am facing financial difficulty I can apply for financial assistance.

I understand and acknowledge that if any unpaid amounts owed by me are assigned to a third party for collection; I will be responsible for paying attorney fees, interest, court costs, and others costs of collection, including collection agency fees.

I authorize Medicare, Medicaid, Blue Shield, and all other commercial payers to pay St. Vincent Health on my behalf for any services furnished to me by the provider.

This forma also authorizes my physician to release any medical information necessary to process insurance claims, provide necessary treatments, and cover general health care operations. This includes allowing the release of information to any specialty car provider or entity for which that I am referred.

I certify that I have read this assignment of benefits, that the information given by me is correct, and that I agree to all of the provisions contained in it.

_________________________________ ________________
Patient or Parent/Legal Guardian Signature Date

_________________________________ ________________
Office Representative Signature Date

SPORT AND PERFORMANCE PSYCHOLOGY SERVICES
Personal Information Form

Instructions: To assist us in helping you, please complete this form as fully and openly as possible. All private information is held in strictest confidence within legal limits.

What is (are) your main reason(s) for this visit?

____
____
____
____
____

How long has this problem persisted? ____

Were you referred for counseling? [ ] YES [ ] NO
If yes who referred you? _______________________________________

Have you received counseling services in the past? [ ] Yes [ ] No
If yes please describe:

____
____

Name of your primary or team physician: ____

List any relevant past or present physical concerns (high blood pressures, headaches, etc.)

____
____
____

Medical Conditions:

Medical Disorder/Problem	Date of Diagnosis	Description of problem. Please write on the back of this form if necessary

Medication History:

Medication	Dosage	Frequency	Start date – End date	Reason for discontinuing

On average, how many hours of sleep do you get daily? ______________________________

Do you have problems sleeping? [ ] YES [ ] NO
If yes please describe:

____
____
____

Have you gained/lost over 10 pounds in the past year? [ ] YES [ ] NO
If yes, was the gain/loss on purpose/ [ ] YES [ ] NO

Describe your appetite level (during the past week):
[ ] poor appetite [ ] average appetite [ ] high appetite

Describe your energy level (during the past week):
[ ] low energy [ ] moderate energy [ ] high energy

Family History

Birth / Adoptive / Foster Mother's Name: ______________________ Age _____ Education (Yrs) ________
Occupation: ______________________________ If deceased, how old were you when she died ________
Briefly describe your Mother:

____
____

How well do you get along with your mother: [ ] poorly [ ] average [ ] well

Birth / Adoptive / Foster Father's Name: ______________________ Age _____ Education (Yrs) ________
Occupation: ______________________________ If deceased, how old were you when he died ________

Briefly describe your father:

____
____

How well do you get along with your father: [ ] poorly [ ] average [ ] well

Have there been any major changes within the family life or the patient's living situation that have affected the patient's functioning (e.g., deaths, moves, divorces, loss of job, etc)? ☐ No ☐ Yes (describe below)

Event Date

____
____
____
____

If your parents are separated or divorces, how old were you when it occurred? ______________________

Were you adopted or raised with parent other than your biological parents? [ ] YES [ ] NO

Number of brother(s): _______ Ages: _____ _____ _____ _____ _____ _____

Number of sister(s): _______ Ages: _____ _____ _____ _____ _____ _____

Briefly describe your relationship with your brothers and sisters:

____

____

Which of the following best describes the family in which you grew up?

(Circle One)

Warm and Accepting Average Hostile & Fighting

1 2 3 4 5 6 7 8 9

Allowed me to be very independent Average Attempted to control me

1 2 3 4 5 6 7 8 9

Check the behaviors and symptoms that cause you difficulty at the present time:

_____Academic performance
_____Aggression
_____Alcohol problems
_____Anger
_____Anxiety
_____Avoiding people
_____Depression
_____Drug problems
_____Eating problems
_____Elevated Mood
_____Fatigue
_____Hallucinations
_____Hopelessness
_____Impulsiveness
_____Irritability
_____Loneliness
_____Memory difficulties
_____Mood shifts
______Panic attacks
______Phobias/fears
______Recurring thoughts
_____Sexual difficulties
_____Sleeping problems
_____Sport performance
_____Suicidal thoughts
_____Worrying
_____Other (specify :) _______

Please give examples of how each of the symptoms checked impairs your ability to function (e.g., socially, emotionally, physically, athletically, etc.): ____

____

____

____

____

Educational History

Were there any identified learning disabilities during school years? Yes No
If yes, please describe:

____

Was the patient in special education? Yes No
If yes, for what reason? ____

Other concerns about possible academic difficulties that were not identified? Yes No
If yes, please describe:

____

Substance Use

How many alcoholic drinks a day does the patient consume and what kind?

____

At what age did the patient start drinking? ______ When was the patient's last drink of alcohol? _____

Has the patient ever experienced problems due to alcohol consumption, and if so, please describe:

____

Is there a family problem of alcohol abuse, and if so, please describe:

____

Does the patient smoke cigarettes, pipes, cigars, or chew tobacco? ☐ Yes ☐ No
If yes, please describe frequency and amount:

____

Legal

Has the patient had any involvement with the legal system? Yes No

Is the patient currently on parole? Yes No

Is the patient current on probation? Yes No

If the patient has had involvement with the legal system, please describe each incident, including the reason for involvement, if the patient was arrested, on what charge the patient was arrested, and what was the outcome of a trial. Please include each length of incarceration.

Additional Information

Sport/Team: ____

Event or Position in Sport: ____

Issues most affecting your Performance:

____

____

____

List your 3 greatest strengths:

____

____

____

List your 3 greatest weaknesses:

____

____

____

What are your goals for counseling (what would you like to change)?

____

____

____

Please use the following space to write in any additional concerns or information that were not addressed in this questionnaire.

____

____

____

THANK YOU. PLEASE RETURN THIS PAPERWORK TO SUSIE WOLFE.