Mental Health History Form

Name _____ **Date** _____ **UID** _____

Team _____ **Email** _____ **Phone** _____

The following questionnaire is being administered and reviewed by the University of Maryland Clinical and Sports Psychology Program. The questionnaire is meant to assess the impact of COVID-19 on you, your readiness to return to sport, and your general mental well-being. We will reach out to follow up with you as indicated based on your responses. When relevant to your overall health and wellness, information may be shared with other members of the University of Maryland Sports Medicine Team. Information shared in this quesitonnaire will NOT be shared with anyone outside of the Sports Medicine team (including coaches, strength and conditioning, administration, etc.).

By checking this box, I acknowledge the purpose of this questionnaire and who this information will be shared with. ☐

Please indicate which team you are on:

- ☐ Baseball
- ☐ Men's Basketball
- ☐ Football
- ☐ Golf
- ☐ Men's Lacrosse
- ☐ Men's Soccer
- ☐ Men's Track and Field
- ☐ Wrestling
- ☐ Women's Basketball
- ☐ Cross Country
- ☐ Field Hockey
- ☐ Women's Golf
- ☐ Gymnastics
- ☐ Women's Lacrosse
- ☐ Women's Soccer
- ☐ Tennis
- ☐ Women's Track and Field
- ☐ Volleyball
- ☐ Softball

Over the past 2 weeks, how often have you been bothered by the following problems?	**Not at all**	**Several Days**	**Over Half the Days**	**Nearly Every Day**
1. Little interest or pleasure in doing things	☐	☐	☐	☐
2. Feeling down, depressed or hopeless	☐	☐	☐	☐
3. Trouble falling asleep, staying asleep, or sleeping too much	☐	☐	☐	☐
4. Feeling tired or having little energy	☐	☐	☐	☐
5. Poor appetite or over eating	☐	☐	☐	☐
6. Feeling bad about yourself- or that you're a failure or have let yourself or your family down	☐	☐	☐	☐
7. Trouble concentrating on things, such as reading the newspaper or watching television	☐	☐	☐	☐

8. 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 a lot more than usual	☐	☐	☐	☐
9. Thoughts that you would be better off dead or hurting yourself in some way	☐	☐	☐	☐

Please use the following scale to indicate how often you have been bothered by the following problems, in the LAST TWO WEEKS.

0= Not at all
1= Several days
2= More than half the days
3= Nearly every day

1. Feeling nervous, anxious, or on edge	○ 0	○ 1	○ 2	○ 3
2. Not being able to stop or control worrying	○ 0	○ 1	○ 2	○ 3
3. Worrying too much about different things	○ 0	○ 1	○ 2	○ 3
4. Trouble relaxing	○ 0	○ 1	○ 2	○ 3
5. Being so restless that it is hard to sit still	○ 0	○ 1	○ 2	○ 3
6. Becoming easily annoyed or irritable	○ 0	○ 1	○ 2	○ 3
7. Feeling afraid, as if something awful might happen	○ 0	○ 1	○ 2	○ 3

Please add the total of the items above and enter total score here

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

I have been/am currently under the care of a mental health professional. If Yes: When was the date of your last visit? Please provide the name of your provider:	Yes	No
The University of Maryland Athletic Department has a Clinical and Sport Psychologist on staff that you can talk with about concerns on this form, or any other concerns you may have. Would you like to schedule a meeting with a provider?	Yes	No

This Section to be completed by a Sports Medicine Provider after reviewing the above answers.

Reviewed By:

Provider Name (Print) _____ Signature _____ Date _____

Recommendations: PHQ-9 total = _____ GAD-7 Total = _____

☐ Same day follow up with Sport Psychology ☐ Future follow up with Sport Psychology ☐ No action