

**UNIVERSITY OF MISSOURI**  
**Athletics Department**



**Student-Athlete**  
**Educational Enrichment Assessment**

*“The Total Person Program is dedicated to developing the total student-athlete. Through the program's comprehensive services, Mizzou student-athletes receive top quality assistance to ensure their success. The Total Person Program understands the pressures and special needs of our student-athletes and works closely with them to monitor their development and make certain their experience at Mizzou is a positive one. The Total Person Program provides MU student-athletes with a team of trained professionals to assist with the rigors of collegiate academics and athletics. Each student-athlete is supported relative to his or her individual needs and goals. The TPP Staff provides many different services for its student-athletes.”*

The Total Person Program wants to be able to provide you with any support you might need to remove barriers to your success. Education-impacting disabilities and personal or family problems can compromise your ability to perform well academically and athletically. This survey asks questions about your family, medical, and educational history to identify your academic strengths and weaknesses. Please complete the following questionnaire honestly and in detail. The more information you provide the more academic support and campus resources we can use to help you reach your potential.

*Confidentiality regarding your answers to these questions will be strictly maintained and respected. However, information may be shared with appropriate professionals in the course of consultation when in the best interest of the student-athlete.*

I have read and understand the above information.

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Student-Athlete Signature

*Created by, Tami Chievous*

*Administering the Assessment, Tami Chievous and Brad Ekwerekwu*

**PLEASE PRINT CLEARLY**

Name \_\_\_\_\_ Date \_\_\_\_\_

Sport \_\_\_\_\_ Date of Birth \_\_\_/\_\_\_/\_\_\_ Gender ( ) Male ( ) Female

Are you a freshman or a transfer student? \_\_\_\_\_

Phone Number \_\_\_\_\_

Email Address \_\_\_\_\_

Hometown, State \_\_\_\_\_

**Basic Information**

1. Where did you go to high school? \_\_\_\_\_

2. How many different high schools have you attended? \_\_\_\_\_

3. About how many people were in your graduating class? \_\_\_\_\_

4. How many different schools have you attended prior to high school? \_\_\_\_\_

5. Generally, do you tend to struggle with a certain subject? If so, what subject and why?

\_\_\_\_\_

6. On a scale of 1 to 5 (1 is the lowest, 5 is the highest) how do you rate yourself academically?

Math \_\_\_\_\_ Reading \_\_\_\_\_ Writing \_\_\_\_\_ Studying \_\_\_\_\_

7. On a scale of 1 to 5 (1 is the lowest, 5 is the highest) how important is it to your parent(s) or guardian(s) that you earn a college degree?

\_\_\_\_\_

8. On a scale of 1 to 5 (1 is the lowest, 5 is the highest) how committed are you in earning a college degree?

\_\_\_\_\_

9. Where do you see yourself in 5 years? (i.e. college graduate, young professional, professional athlete, in graduate school, etc)

\_\_\_\_\_

10. How do you feel the staff of the Total Person Program can **MOST** help you with your first semester at the University of Missouri? (Check all that apply)

\_\_\_\_\_ Assisting in schedule planning

\_\_\_\_\_ Improving study habits

\_\_\_\_\_ Career planning

\_\_\_\_\_ Assigning you a tutor

\_\_\_\_\_ Ongoing help with managing your time

\_\_\_\_\_ Improving reading skills

\_\_\_\_\_ Assisting in financial aid planning

\_\_\_\_\_ Assisting in various difficulties that may occur in transition from high school to college

**Athletics**

1. On a scale of 1 to 5 (1 is the lowest, 5 is the highest) how important is it to your parent(s) or guardian (s) that you become a starter on your Mizzou athletic team?

\_\_\_\_\_

2. Do you believe you would have attended college if you had not planned to also participate in athletics?

Yes \_\_\_\_\_ No \_\_\_\_\_ Not Sure \_\_\_\_\_

3. Are you concerned about your ability to balance academics and athletics?

\_\_\_\_\_ Not concerned \_\_\_\_\_ Somewhat concerned \_\_\_\_\_ Very concerned

Are there any specific concerns? \_\_\_\_\_

**Please share a little about your family history.**

1. Describe any family or personal issues that you feel may be interfering with your learning:

\_\_\_\_\_

\_\_\_\_\_

2. Are you currently personally responsible for the care and/or well being of anyone other than yourself? If yes, please briefly explain.

\_\_\_\_\_

\_\_\_\_\_

3. Were you adopted?     Yes     No

4. Do either of your parents have a college degree?

    Mother               Father               Step-parent

5. How many of each was living in your household during high school?

Parent (s)     Guardian (s)     Siblings     Other

If other, please explain \_\_\_\_\_

**Language History**

1. What language(s) is/are spoken in your home? \_\_\_\_\_

2. What language(s) were you first exposed to? \_\_\_\_\_

3. If English was not your first language, at what age did you begin to learn English? \_\_\_\_\_

**Health History**

1. Please check any conditions that apply to you now or in the past:

Head Injury               Ear Infections               Asthma

Diabetes               Vision Problems               Allergies

Seizures/Epilepsy               Hearing Loss               High fevers

Passing Out

Surgery (if checked please describe) \_\_\_\_\_

Other (specify): \_\_\_\_\_

2. Have you informed or reported all of the above conditions to your athletic trainer or team physician?               Yes     No

3. Have you ever been hospitalized?               Yes     No

4. If yes, when, why and for how long? \_\_\_\_\_

\_\_\_\_\_

5. Check the following resources you have used:

Psychiatric Care or Diagnosis

Private Counseling/Psychological Services

Visual/Eye Treatments other than Vision Correction

Alcohol/Drug Rehabilitation

Other (specify) \_\_\_\_\_

If you checked one of the above, please describe further: \_\_\_\_\_

\_\_\_\_\_

6. When was your last eye exam? \_\_\_\_\_

7. Are you currently taking any medication?  Yes  No

If yes, please give the name of the medication(s): \_\_\_\_\_

\_\_\_\_\_

8. Have you been on any medication in the past?  Yes  No

If yes, give the name of the medication(s): \_\_\_\_\_

9. Are you currently taking any medication, such as adderall, to increase focus?  Yes  No  
If yes, please explain \_\_\_\_\_

**Substance Use and Abuse History**

1. Have you ever, or do you currently, use any other substances (including others' medications)

Occasionally  Often  No

If yes, which ones? \_\_\_\_\_

2. Do you currently take any supplements? (Including those that can be purchased at GNC)

Yes  No If yes, which ones? \_\_\_\_\_

3. Has anyone ever told you they thought you drank too much?  Yes  No

4. Do you have concerns that you might have an issue with alcohol?  Yes  No

5. Does anyone in your family have a history of alcohol abuse? \_\_\_\_Yes \_\_\_\_No

If yes, please explain \_\_\_\_\_

6. Do your friends frequently engage in alcohol use? \_\_\_\_Yes \_\_\_\_No

7. Do you or have you ever used illegal drugs? \_\_\_\_Yes \_\_\_\_No

Has anyone in your family use/used illegal drugs? \_\_\_\_Yes \_\_\_\_No

If yes, please describe \_\_\_\_\_

8. Have you ever been in trouble because of alcohol/drug use?

\_\_\_\_ Yes \_\_\_\_ No

9. Would you like to speak with someone about these topics? \_\_\_\_Yes \_\_\_\_No

**We realize balancing academics, athletics, and relationships can create stress.**

1. Have you ever had difficulties with attention, concentration or hyperactivity?

\_\_\_\_ Yes \_\_\_\_ No If yes, describe \_\_\_\_\_

2. Have you ever, or do you currently, have sleep difficulties? \_\_\_\_ Yes \_\_\_\_ No

If yes, please describe \_\_\_\_\_

3. How many times a week do you eat breakfast? Please circle below.

0    1    2    3    4    5    6    7

4. Do you have current concerns or thoughts about your weight or body image?

If yes, please describe \_\_\_\_\_

5. Have you ever had problems with anxiety, depression or relationships? \_\_\_\_Yes \_\_\_\_No

If yes, please describe \_\_\_\_\_

6. Have you ever been hospitalized for an emotional problem? \_\_\_\_Yes \_\_\_\_No

7. Have you ever participated in individual or group counseling? \_\_\_\_Yes \_\_\_\_No

If yes, please indicate what type of counseling \_\_\_\_\_

8. Are you concerned that you are or might become homesick? \_\_\_\_\_ Yes \_\_\_\_\_ No

9. Have you ever been homesick? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe \_\_\_\_\_

10. Have you ever engaged in any gambling activities \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe \_\_\_\_\_

11. Have you ever witnessed a traumatic event? \_\_\_\_\_ Yes \_\_\_\_\_ No

If yes, please describe \_\_\_\_\_

12. Would you like to speak with someone about any of the topics above? \_\_\_\_\_ Yes \_\_\_\_\_ No

**Tell us about your educational history**

1. What were your highest SAT/ACT scores? \_\_\_\_\_

Did you have special testing conditions? Please describe \_\_\_\_\_

2. Have you ever received help in school for any education-impacting disabilities? \_\_\_ Yes \_\_\_ No

If yes, when, by whom, and what services were used? \_\_\_\_\_

\_\_\_\_\_

3. If you did have trouble, in what grade did you first start having problems in school? \_\_\_\_\_

What problems were there? \_\_\_\_\_

4. Have you ever been placed in a below current grade level class?

\_\_\_\_\_ Yes \_\_\_\_\_ No

5. Check if any of the following may have contributed to problems in school:

\_\_\_\_\_ Tasks too difficult

\_\_\_\_\_ Home Environment

\_\_\_\_\_ Emotional Problems

\_\_\_\_\_ Managing time

\_\_\_\_\_ Lack of interest in school

\_\_\_\_\_ Poor attendance

6. Check any of the following that present difficulties in your test taking experiences:

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Anxiety   | <input type="checkbox"/> Insufficient Time | <input type="checkbox"/> Multiple Choice   |
| <input type="checkbox"/> True/False  | <input type="checkbox"/> Matching          | <input type="checkbox"/> Fill-in the blank |
| <input type="checkbox"/> Short Essay                                       | <input type="checkbox"/> Long Essay        | <input type="checkbox"/> Calculations      |
| <input type="checkbox"/> Spelling  | <input type="checkbox"/> Grammar           | <input type="checkbox"/> Organization      |
| <input type="checkbox"/> Memory  | <input type="checkbox"/> Background Noises | <input type="checkbox"/> Distractions      |
| <input type="checkbox"/> Filling out scantron sheets (bubbling in answers) |  |  |

7. Would you be interested in being tested for education-impacting, learning style identifications? This test may determine a more successful way for you to achieve higher academic achievement.

Yes  No

**Reading**

1. Do you experience frustration when reading?  Yes  No

If yes, explain \_\_\_\_\_

\_\_\_\_\_

2. Do you like to read?  Yes  No

3. Do you read slowly?  Yes  No

4. Are you comfortable reading out loud?  Yes  No

5. Do you have problems:

Understanding what you read?  Locating the main idea?

Finding the supporting details?  Reading/using maps?

**Math**

1. Do/did you have problems with basic math skills, such as:

- |   |                                      |
|---|--------------------------------------|
| <input type="checkbox"/> Addition                   | <input type="checkbox"/> Geometry    |
| <input type="checkbox"/> Multiplication             | <input type="checkbox"/> Subtraction |
| <input type="checkbox"/> Measurement                | <input type="checkbox"/> Division    |
| <input type="checkbox"/> Managing Personal Accounts | <input type="checkbox"/> Money       |

2. Do you have difficulty with mathematical concepts?  Yes  No

**Expressive Language**

1. Do you have difficulty organizing and/or expressing:

Your thoughts and ideas?  Yes  No

Your emotions?  Yes  No

2. Do you have difficulty re-telling information you've seen, read or heard?  Yes  No

3. Do you use a limited vocabulary when writing?  Yes  No

4. Do you express yourself more effectively when:  Writing  Speaking

**Learning Style**

1. Do you have problems understanding verbal information, such as:

Following verbal directions  Following a multi-step direction

Following a lecture  Misinterpreting what people are saying

2. Do you experience difficulty memorizing material (numbers, dates, names, factual information, etc.)?  Yes  No

3. Do you have problems retrieving info you have learned or stored?  Yes  No

**Academic habits & behaviors**

1. Do you have difficulty interacting with others in an educational setting?  Yes  No

If yes, please explain: \_\_\_\_\_

2. Check all areas that give you trouble:

- |   |   |
|---|---|
| <input type="checkbox"/> Going to class on time                       | <input type="checkbox"/> Difficulty listening to others |
| <input type="checkbox"/> Going to class prepared                      | <input type="checkbox"/> Making new friends             |
| <input type="checkbox"/> Becoming motivated to start school work      | <input type="checkbox"/> Understanding humor            |
| <input type="checkbox"/> Budgeting your time                          | <input type="checkbox"/> Fidgeting/restlessness         |
| <input type="checkbox"/> Sticking with assignment until completed     | <input type="checkbox"/> Test-taking anxiety            |
| <input type="checkbox"/> Difficulty waiting your turn                 | <input type="checkbox"/> Interrupting others            |
| <input type="checkbox"/> Blurting answers before question is finished | <input type="checkbox"/> Sustaining attention           |
| <input type="checkbox"/> Shifting from one task to another            | <input type="checkbox"/> Excessive talking              |
| <input type="checkbox"/> Other (explain) _____                        |   |

**Personal Role Model**

Who is your role model and why? Please briefly describe your role model and the influence they have had on your life.

Is there anything else we should know in order to help you achieve academic success?

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