Sunshine Mental Health
Psychology Services in Powell River, B.C.

Stephanie Kovacs, Ph.D.
Registered Psychologist
4794 Joyce Ave. Powell River, BC V8A-3B6
TEL: (604) 414-7654 Fax: (604) 485-2820
www.sunshinementalhealth.com

MRN:

CONSENT TO TREATMENT

Patient's Name: (print) _____ _____
LAST FIRST

Description of Psychotherapy:
Psychotherapy addresses issues of the whole person. Therapy may address your biology, thoughts, behaviours, relationship(s), and the meaning or purpose of your life. Most forms of therapy are designed to help people change some aspect of their lives to become more responsible, independent human beings. Good treatment is assessment-driven, which means that you may be requested to complete questionnaires or tests to more effectively guide and monitor your treatment progress.

Procedures:
If you decide to take part in therapy, you are agreeing to therapy-related assessment (if requested), homework assignments, and to engage as a collaborator in effecting the desired changes in your life. If you have questions about any procedure, recommendation, or homework assignments, you are free to ask for an explanation at any time. You may decline to take part in any part of therapy or withdraw at any time.

Risks and Benefits of Therapy:
Many people find the process of change and recommendations toward change difficult. During the process, you may experience some anxiety, guilt, loss, sleeplessness, or a heightened sense of awareness. Therapy can sometimes precipitate some interpersonal conflict. The process of change can be quite difficult with varied results. There are no guarantees that therapy will be effective for any individual. In general, therapy does tend to lead toward greater health and contentment. You are likely to become much more self-aware, self-confident, and self-content. Happier people tend to be happier in their personal, professional, and social relationships.

Confidentiality:
There are legal and practical limits to confidentiality. For example, if your treatment is paid by a third party provider, they may have the right to request confidential material or require progress reports. A court may order disclosure of records. Administrative staff and the regulatory body of psychologists will have access to information on a need-to-know basis. On occasion, Dr. Kovacs may discuss your case with another psychologist colleague as part of routine practice. These individuals agree to keep material confidential, and any identifying information is withheld or disguised as much as possible. Records will be stored for seven years from the age of majority in a secured location as per requirements set under the Health Professionals Act.

Confidentiality will be legally breeched if you:

- Threaten to harm yourself or are at-risk of incurring serious harm
- Threaten to harm others or engage in reckless behaviour that is likely to result in serious harm to others
- Disclose neglect, physical, emotional, or sexual abuse of a child, elder, or other vulnerable population
- If you have been told not to drive but continue do so
- Court order

Consent Statement:

I,_____ have been told and understand the limits of confidentiality, risks and benefits of treatment. This statement certifies the following: that I am 19 years of age or older, that I consent to assessment, and all my questions have been answered. (Alternately, that I am the legal guardian of the named patient that is under 19 years of age).

_____ Date: ____/_____/_____
SIGNATURE OF PATIENT / GUARDIAN MM DD YYYY

S. KOVACS, PH.D.
REGISTERED PSYCHOLOGIST
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ADULT HISTORY

PLEASE PRINT

The information your provide is strictly confidential and will be used only to aid in your care. Exceptions to confidentiality discussed in your first visit also apply to the information on this form. If you feel uncomfortable answering any item, please leave it blank and discuss with Dr. Kovacs.

PERSONAL INFORMATION

_____ _____ _____
FIRST NAME LAST NAME MI

DATE OF BIRTH: _____ _____ _____ _____
MONTH DAY YEAR AGE

_____ _____ _____
GENDER: RACE/ETHNICITY BIRTHPLACE

CONTACT INFORMATION

_____ _____ _____ _____
STREET ADDRESS CITY PROV POSTAL

HOME PH: ____ - _____ - _____ OK TO LEAVE VOICEMAIL? ☐Y ☐N
CELL PH: ____ - _____ - _____ OK TO LEAVE VOICEMAIL? ☐Y ☐N TEXT? ☐Y ☐N
WORK PH: ____ - _____ - _____ OK TO LEAVE VOICEMAIL? ☐Y ☐N
EMAIL ADDRESS: _____

EMERGENCY CONTACT:

FIRST NAME: _____ LAST NAME: _____
HOME PH: _____ CELL PH: _____ WORK PH: _____
RELATION TO PATIENT: _____

OCCUPATIONAL INFORMATION

EMPLOYMENT STATUS: ☐FULL-TIME? ☐PART-TIME? ☐ UNEMPLOYED? ☐ RETIRED?
CURRENT OCCUPATION: _____
COMPANY NAME: _____
#YEARS WITH COMPANY: _____

HIGHEST LEVEL OF EDUCATION: _____

_____ _____
DEGREE/CERTIFICATE TITLE: INSTITUTION:

_____
YEAR GRADUATED

SOCIAL INFORMATION

RELATIONSHIP STATUS: _____
SPOUSE/PARTNER NAME (IF APPLICABLE):_____
PARTNER AGE: _____ #YEARS TOGETHER: _____

LIST CHILDREN, THEIR NAMES, AND ANY SIGNIFICANT PROBLEMS:

_____
_____
_____

RELIGION: _____
HOW IMPORTANT IS RELIGION/SPIRITUALITY TO YOU? _____

LIST ALL MEMBERS OF HOUSEHOLD AND THEIR RELATIONSHIP TO YOU:

_____
_____

ANY CURRENT FINANCIAL STRESS:

IN GENERAL, HOW WOULD YOU DESCRIBE THE WAY YOU GET ALONG WITH PEOPLE?

HOW MANY CLOSE FRIENDS AND FAMILY MEMBERS CAN YOU RELY ON? _____

PLEASE DESCRIBE YOUR SOCIAL SUPPORT NETWORK:

DESCRIBE ANY RELATIONSHIP PROBLEMS:

DESCRIBE ANY PROBLEMS WITH REGARDS TO SEX:

MEDICAL HISTORY

DOCTOR'S NAME:_____

CURRENT PRESCRIPTIONS:

_____

_____

_____

PAST PRESCRIPTIONS:

_____

_____

_____

SIGNIFICANT HEALTH HISTORY OR CONDITIONS:

SUBSTANCE USE

CURRENT MONTHLY OR YEARLY USE

_____

_____

PAST:

_____

_____

LIST ANY EXPERIENCES WITH DRUG REHAB PROGRAMS OR CURRENT RECOVERY GROUPS:

_____

_____

LEGAL HISTORY

LIST ANY CRIMINAL CHARGES OR OPEN LEGAL DISPUTES:

LIFESTYLE

PLEASE DESCRIBE YOUR CURRENT LEVEL OF PHYSICAL ACTIVITY: (Eg., sports, activities, exercise, etc.)

PLEASE DESCRIBE YOUR CURRENT DIET / EATING HABITS: (Eg. vegan, low sodium, excessive eating when stressed; lack of appetite, repetitive dieting, etc.)

PLEASE DESCRIBE ANY PROBLEMS WITH SLEEP:

PSYCHOLOGICAL HISTORY

PREVIOUS COUNSELLING? (LIST NAMES, DATES, AND THE PRIMARY PROBLEMS):

EG., DR. SUSAN SMITH 2010-2012 DEPRESSION

_____

_____

PREVIOUS HOSPITALIZATIONS FOR PSYCHIATRIC PROBLEMS?

_____

_____

PREVIOUS TESTING / ASSESSMENTS?

_____

_____

FAMILY MENTAL HEALTH HISTORY (*EG, MOTHER (DEPRESSION))*

MATERNAL SIDE _____

_____

PATERNAL SIDE _____

_____

HAVE YOU EVER CONTEMPLATED SUICIDE OR HURINT YOURSELF? PLEASE SHARE

DO YOU CURRENTLY HAVE ANY SUICIDAL IDEAS? IF SO, PLEASE EXPLAIN:

PLEASE DESCRIBE ANY PROBLEMS YOU MIGHT HAVE HAD IN CHILDHOOD OR ADOLESCENCE:

HAVE YOU EVER EXPERIENCED A SERIOUS TRAUMA? IF SO, PLEASE EXPLAIN:

TELL ABOUT ANY PROBLEMS WITH DEPRESSION:

TELL ABOUT ANY PROBLEMS WITH ANXIETY:

TELL ABOUT ANY PROBLEMS WITH ANGER/AGGRESSION:

HOW DO YOU EXPLAIN WHAT IS GOING ON IN YOUR LIFE?

WHAT ARE YOUR EXPECTATIONS FOR THERAPY? WHAT SPECIFIC GOALS WOULD YOU LIKE TO ADVANCE?

ANY OTHER IMPORTANT INFORMATION?

WHO REFERRED YOU TO SUNSHINE MENTAL HEALTH?

_____

DASS 21

NAME _____ DATE _____

Please read each statement and circle a number 0, 1, 2 or 3 which indicates how much the statement applied to you over the past week. There are no right or wrong answers. Do not spend too much time on any statement.

The rating scale is as follows:

0 Did not apply to me at all - NEVER

1 Applied to me to some degree, or some of the time – SOMETIMES

2 Applied to me to a considerable degree, or a good part of time – OFTEN

3 Applied to me very much, or most of the time - ALMOST ALWAYS

		Select 0 1 2 3	FOR OFFICE USE D	A	S
1.	I found it hard to wind down				
2.	I was aware of dryness of my mouth				
3.	I couldn't seem to experience any positive feeling at all				
4.	I experienced breathing difficulty (eg, excessively rapid breathing, breathlessness in the absence of physical exertion)				
5.	I found it difficult to work up the initiative to do things				
6.	I tended to over-react to situations				
7.	I experienced trembling (eg, in the hands)				
8.	I felt that I was using a lot of nervous energy				
9.	I was worried about situations in which I might panic and make a fool of myself				
10.	I felt that I had nothing to look forward to				
11.	I found myself getting agitated				
12.	I found it difficult to relax				
13.	I felt down-hearted and blue				
14.	I was intolerant of anything that kept me from getting on with what I was doing				
15.	I felt I was close to panic				
16.	I was unable to become enthusiastic about anything				
17.	I felt I wasn't worth much as a person				
18.	I felt that I was rather touchy				
19.	I was aware of the action of my heart in the absence of physical exertion (eg, sense of heart rate increase, heart missing a beat)				
20.	I felt scared without any good reason				
21.	I felt that life was meaningless				
		TOTALS	0	0	0