Sunshine Mental Health
Psychology Services in Powell River, B.C.
A Division of 1240001 B.C. Ltd.

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MRN:

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 HURTING 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?

ANY OTHER IMPORTANT INFORMATION?

WHO REFERRED YOU TO SUNSHINE MENTAL HEALTH?

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