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

STEPHANIE KOVACS, PH.D.
REGISTERED PSYCHOLOGIST
4794 JOYCE AVE. POWELL RIVER, BC V8A-3B6
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WWW.SUNSHINEMENTALHEALTH.COM

MRN:

CONSENT TO ASSESSMENT ADULT

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

You have been referred for psychological assessment by yourself, physician, or third party insurer. If you have questions about any procedure or test being administered, you are free to ask for an explanation at any time. You may decline to take part in an assessment, procedure, intervention, or homework assignment at your discretion. You may decline to answer any question.

Description of Psychometric Testing:

Psychometric testing is a means of describing human strengths and weaknesses when material is presented in a standardized administration. For this reason, the test administration may seem rather formal and impersonal. Your results will be compared to those of the standardization sample. Standardization is the scientific means of helping researchers and clinicians measure specific qualities about you while minimizing any interference from other qualities. This allows for a clearer picture of your abilities and aids in understanding your specific qualities as compared to other people of similar backgrounds. The test(s) you will complete may help your doctor(s) to know how to better treat you as a unique individual.

Procedures:

Depending on the test(s) that you are asked to complete, you will be asked to perform a specific task. Tasks can range from solving word puzzles, drawing lines, looking at objects, answering direct questions, or even designing things with blocks. Depending on the test(s), your assessment may be as brief as 15 minutes or as long as several hours or days. Please understand for the sake of test security, Dr. Kovacs may not be able to give you much feedback on your performance until all the results are compiled. Some tests are copyrighted and kept under strict privacy. This means that you may not be able to review the specific test items or even your own answers at the completion of the testing without a court order.

Risks or Discomfort:

Many people find the testing procedures interesting and enjoyable. Depending on the test(s) administered, you may develop a mild headache. If this happens, it is quite normal. Psychological assessment involves testing your thinking and perception. By nature of the procedure, you may feel some boredom or fatigue.

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 to yourself
- 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 assessment. 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.

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

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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 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?

_____

LEVEL 2—Depression—Adult*

*PROMIS Emotional Distress—Depression—Short Form

Name: _____ **Age:** ____ **Sex:** ☐ **Male** ☐ **Female** **Date:**_____

If the measure is being completed by an informant, what is your relationship with the individual receiving care? _____

In a typical week, approximately how much time do you spend with the individual receiving care? _____ hours/week

Instructions: On the DSM-5 Level 1 cross-cutting questionnaire that you just completed, you indicated that *during the past 2 weeks* you (the individual receiving care) have been bothered by "no interest or pleasure in doing things" and/or "feeling down, depressed, or hopeless" at a mild or greater level of severity. The questions below ask about these feelings in more detail and especially how often you (the individual receiving care) have been bothered by a list of symptoms **during the past 7 days. Please respond to each item by marking (✓ or x) one box per row.**

							Clinician Use
In the past SEVEN (7) DAYS....							**Item Score**
		Never	**Rarely**	**Sometimes**	**Often**	**Always**	
1.	I felt worthless.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
2.	I felt that I had nothing to look forward to.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
3.	I felt helpless.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
4.	I felt sad.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
5.	I felt like a failure.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
6.	I felt depressed.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
7.	I felt unhappy.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
8.	I felt hopeless.	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	
						Total/Partial Raw Score:	
						Prorated Total Raw Score:	
						T-Score:	

OM COUNSELING ASSESSMENT FOR BURNS ANXIETY INVENTORY

Instructions: Choose the best answer for how the client has felt over the past week, including today.
Mark the answer that best describes how much that symptom or problem has bothered the client.

0 = Not at all 1 = Somewhat 2 = Moderately 3 = A lot

Category 1: Anxious Feelings

1. Anxiety, nervousness, worry, or fear	0	1	2	3
2. Feeling that things around you are strange, unreal, or foggy	0	1	2	3
3. Feeling detached from all or part of your body	0	1	2	3
4. Sudden unexpected panic spells	0	1	2	3
5. Apprehension or sense of impending doom	0	1	2	3
6. Feeling tense, stressed, "uptight", or on edge	0	1	2	3

Category II: Anxious Thoughts

7. Difficulty concentrating	0	1	2	3
8. Racing thoughts or having your mind jump from one thing to the next	0	1	2	3
9. Frightening fantasies or daydreams	0	1	2	3
10. Feeling that you're on the verge of losing control	0	1	2	3
11. Fears of cracking up or going crazy	0	1	2	3
12. Fears of fainting or passing out	0	1	2	3
13. Fears of physical illnesses or heart attacks or dying	0	1	2	3
14. Concerns about looking foolish or inadequate in front of others	0	1	2	3
15. Fears of being alone, isolated, or abandoned	0	1	2	3
16. Fears of criticism or disapproval	0	1	2	3
17. Fears that something terrible is about to happen	0	1	2	3

Category III: Physical Symptoms

18. Skipping or racing or pounding of the heart (sometimes called palpitations)	0	1	2	3
19. Pain, pressure, or tightness in the chest	0	1	2	3
20. Tingling or numbness in the toes or fingers	0	1	2	3
21. Butterflies or discomfort in the stomach	0	1	2	3
22. Constipation or diarrhea	0	1	2	3
23. Restlessness or jumpiness	0	1	2	3
24. Tight, tense muscles	0	1	2	3
25. Sweating not brought on by heat	0	1	2	3
26. A lump in the throat	0	1	2	3
27. Trembling or shaking	0	1	2	3
28. Rubbery or "jelly" legs	0	1	2	3
29. Feeling dizzy, lightheaded, or off balance	0	1	2	3
30. Choking or smothering sensations or difficulty breathing	0	1	2	3
31. Headaches or pains in the neck or back	0	1	2	3
32. Hot flashes or cold chills	0	1	2	3
33. Feeling tired, weak, or easily exhausted	0	1	2	3

Scoring: **In order to obtain an appropriate BAI rating, calculate the sum of all the circled numbers; and write in the BAI Rating Box to the right**

BAI RATING

0-4	Minimal or no anxiety	21-30	Moderate anxiety
5-10	Borderline anxiety	31-50	Severe Anxiety
11-20	Mild Anxiety	51-99	Extreme anxiety or panic

*****A score of 21 or above indicates the need for an Anxiety Treatment Plan*****

_____ _____ _____

Signature of Interviewer **Date** **Time**