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:

NOTE: THIS FORM CANNOT BE COMPLETED ELECTRONICALLY. PLEASE PRINT AND SIGN BY HAND.

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

CONSENT TO TREATMENT CHILD

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 or your child:
- Threatens to harm him/herself or is at-risk of incurring serious harm
- Threaten to harm others or engage in reckless behavior that would put others in serious harm
- Disclose neglect, physical, emotional, or sexual abuse of a child, elder, or other vulnerable population
- Has been told not to drive but continues do so (adolescents only)
- Court order

Please note: *If the child has another parent/legal guardian who does not live with yourself and the child, and is not aware of the therapy (e.g., joint custody agreement), he/she must be made aware, and* ***Dr. Kovacs must have written consent from him/her****, before the treatment may begin. If this applies to your child, please inform Dr. Kovacs so that the appropriate parent/legal guardian may be contacted. Thank you.*

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Consent Statement:

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

_____ Date: ____/_____/_____ _____

SIGNATURE OF PARENT / GUARDIAN MM DD YYYY NAME OF CHILD

_____ Date: _____/_____/_____

2ND PARENT / GUARDIAN SIGNATURE (IF APPLICABLE) MM DD YYYY

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CHILD 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.

CHILD INFORMATION

_____ _____ _____
FIRST NAME LAST NAME MI

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

_____ _____ _____
GENDER: RACE/ETHNICITY BIRTHPLACE

PRIMARY ADDRESS

_____ _____ _____ _____
STREET ADDRESS CITY PROV POSTAL

EMERGENCY CONTACT:

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

PARENT INFORMATION

PARENT #1

_____ _____ _____ _____
FIRST NAME LAST NAME AGE RELATION

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: _____

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

PARENT #2

_____ _____ _____ _____
FIRST NAME LAST NAME AGE RELATION

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: _____

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

FAMILY INFORMATION

PLEASE LIST ANY SIBLINGS, STEP-SIBLINGS, OR HALF-SIBLINGS; THEIR AGE; AND HOUSEHOLD.
Eg., Susan (sister, age 12, same home) Brian (step-brother, age 15, dad's home)

ACADEMIC INFORMATION

_____ _____ _____
SCHOOL GRADE TEACHER

DESCRIBE ANY SPECIAL PROGRAMS OR ACCOMMODATIONS YOUR CHILD UTILIZES AT SCHOOL
(EG, IEP, ONLINE CLASSES, HONORS, CMA, ETC.)

DESCRIBE HOW YOUR CHILD IS DOING ACADEMICALLY AND LIST ANY SPECIFIC AREAS OF CONCERN OR HIGH ACHIEVEMENT.

SOCIAL INFORMATION

RELIGION: _____

HOW IMPORTANT IS RELIGION/SPIRITUALITY IN YOUR HOUSEHOLD? _____

ANY CURRENT MARITAL STRESS IN THE HOME:

ANY CURRENT FINANCIAL STRESS:

IN GENERAL, HOW WOULD YOU DESCRIBE THE WAY YOUR CHILD GETS ALONG WITH PEOPLE?

HOW MANY CLOSE FRIENDS CAN YOUR CHILD RELY ON? _____

PLEASE DESCRIBE YOUR SOCIAL SUPPORT NETWORK:

DESCRIBE ANY PEER PROBLEMS:

IS YOUR CHILD SEXUALLY ACTIVE THAT YOU KNOW OF? ____ Y ____ N

LIST ANY REGULAR ACTIVITIES OR SPORT WITH WHICH YOUR CHILD IS INVOLVED:

MEDICAL HISTORY

DOCTOR'S NAME:_____

CURRENT PRESCRIPTIONS:

_____

_____

_____

PAST PRESCRIPTIONS:

_____

_____

_____

SIGNIFICANT HEALTH HISTORY OR CONDITIONS:

SUBSTANCE USE **- IDENTIFY ANY USAGE YOU ARE AWARE OF FOR YOUR CHILD**

CURRENT:

_____

_____

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 CHILD'S CURRENT LEVEL OF PHYSICAL ACTIVITY:

PLEASE DESCRIBE YOUR CHILD'S CURRENT DIET / EATING HABITS:

PLEASE DESCRIBE ANY PROBLEMS WITH YOUR CHILD'S SLEEP:

DEVELOPMENTAL HISTORY

DESCRIBE ANY SIGNIFICANT PROBLEMS DURING PREGNANCY:

CHECK ONE: ☐ VAGINAL DELIVERY ☐ C-SECTION

DESCRIBE ANY SIGNIFICANT PROBLEMS DURING DELIVERY:

CHILD'S WEIGHT AT BIRTH: _____

HOW WOULD YOUR DESCRIBE YOUR CHILD'S GENERAL TEMPERAMENT IN INFANCY?

PLEASE IDENTIFY ANY DEVELOPMENTAL DELAYS REGARDING MILESTONES:
PHYSICAL (Eg., sitting, rolling, crawling, walking, toileting, etc.)

COGNITIVE & COMMUNICATION (Eg., speaking, counting, vocabulary, etc.)

SOCIAL & EMOTIONAL (Eg., empathy, making new friends, approaching others, integrating, right vs. wrong, etc.)

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 _____

_____

HAS YOUR CHILD EVER DISCLOSED THOUGHTS OF SUICIDE OR HURTING HIM/HERSELF? DESCRIBE

DO YOU BELIEVE YOUR CHILD IS CURRENTLY SUICIDAL? IF SO, PLEASE EXPLAIN:

PLEASE DESCRIBE ANY SIGNIFICANT EVENTS THAT YOU BELIEVE HAVE AFFECTED YOUR CHILD:

HAS YOUR CHILD EVER EXPERIENCED A SERIOUS TRAUMA/ABUSE? IF SO, PLEASE EXPLAIN:

TELL ABOUT ANY PROBLEMS WITH DEPRESSION:

TELL ABOUT ANY PROBLEMS WITH ANXIETY:

TELL ABOUT ANY PROBLEMS WITH ANGER/AGGRESSION OR DEFIANCE:

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

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

ANY OTHER IMPORTANT INFORMATION?

WHO REFERRED YOU TO SUNSHINE MENTAL HEALTH?

_____