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PSYCHIATRIC OUTPATIENT CLINIC
123 Main Street
Anywhere, US 12345-6789

Date of Exam: 6/8/2016
Time of Exam: 4:41:47 PM

Patient Name: Little, Aimee
Patient Number: 1000010659748

Bio-Psychosocial Assessment

History: Mrs. Little is a widowed Canadian 38 year old woman. Her chief complaint is, "I cannot eat, sleep, bathe or sit still since my husband died three months ago."

The following information on her depression was provided by: Mrs. Little
Symptoms of a depressive disorder are described by Mrs. Little. Her depressive symptoms began insidiously over a period of months. She describes episodes of chronic or daily depression.
Current Symptoms: She reports that her appetite is decreased. Mrs. Little is no longer enjoying previously enjoyed activities. She reports "Crying Spells" or episodes. Feelings of sadness have been reported.
Suicidality: Mrs. Little denies suicidal ideas or intentions.

Mrs. Little exhibits symptoms of anxiety. Anxiety symptoms are occurring daily. She reports occurrences of difficulty concentrating. When anxious, she reports fears of losing control or of dying. Mrs. Little describes an exaggerated startle response.

Mrs. Little denies any chemical dependency problems.
Mrs. Little denies any symptoms of ADHD.
Mrs. Little denies ever having been sexually, physically or emotionally abused.

Past Psychiatric History:
To be completed by Dr. Smith.

Social/Developmental History:
Mrs. Little is a widowed 38 year old woman. She is Canadian. She is a Christian.
Relationship/Marriage:
Mrs. Little is a widow.
Children:
Mrs. Little has three adult children.
Activities of Daily Living:
Leisure:
Past leisure Activities:
*Church Activities
*Card Games

Barriers to Treatment:
Emotional:
*Emotional or psychological problems are a barrier to treatment success: Emotional problems will be addressed via the treatment plan. (Profound grief.)
Client's Goals:
"I just want to feel better."

Coping Strengths:
Family:
*Strong Family Ties
*Family is Intact and Financially and Emotionally Supportive
Financial:
*Financially secure
Housing Status:
Mrs. Little owns a condo. It is reportedly in good repair and safe.
Strengths/Assets:
Mrs. Little's strengths and assets are as follows:
Motivated for Treatment
Physical:
*Healthy

Family History:
Father known to have anxiety.
Sister thought to have depression.
Daughter treated as outpatient for a learning disorder.
Family psychiatric history is otherwise negative. There is no other history of psychiatric disorders, psychiatric treatment or hospitalization, suicidal behaviors or substance abuse in closely related family members.

Medical History:
To be completed by Dr. Smith.

Exam: Mrs. Little appears glum, inattentive, disheveled, and is tearful during our interview. Her speech is mumbled, scanty, slow, and soft. Language skills were not formally tested. There are signs of severe depression. Demeanor is sad. Demeanor is glum. She appears listless and anergic. Thought content is depressed. Slowness of physical movement helps reveal depressed mood. Facial expression and general demeanor reveal depressed mood. She denies having suicidal ideas. Affect is restricted in range. There are no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. Suicidal ideas or intentions are denied. Insight into problems appears to be poor. Judgment appears fair. There are signs of anxiety.
Anxiety is present as evidenced by the following:
*Restlessness
*Startle Response

A short attention span is evident. Mrs. Little made poor eye contact during the examination.

Instructions / Recommendations / Plan:
A clinic or outpatient treatment setting is recommended because patient is impaired to the degree that there is relatively mild interference with interpersonal /occupational functioning.
Crisis Focused Therapy:
The risks and benefits of outpatient therapy were explained to Mrs. Little.

Return 1 week, or earlier if needed.

Notes & Risk Factors:
Acute Grief: Death of husband 4/1/15

90791 Bio-Psychosocial Initial Assessment

Time spent face to face with patient and/or family and coordination of care: 45 minutes
Session start: 10:00 AM
Session end: 10:45 AM

Jane Smith, LCSW

Electronically Signed
By: Jane Smith, LCSW
On: 6/8/2016 4:43:32 PM

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