WK 7 Assignment 2 PRAC 6635, Meditrek Patient Number 83 (seen 7/8/22)

Patient Name KW

28 y/o Caucasian Female

Office Visit

7/8/2022

GAD (generalized anxiety disorder) +1 more

Dx Anxiety

Reason for Visit

Progress Notes

Initial Outpatient Psychiatric Evaluation

Patient Name: KW

Date of Evaluation: 07/08/22

Identification: Kristen Watts is a 27 yrs old, going through a divorce, employed, Caucasian female who presents for psychiatric evaluation. Information for this evaluation was obtained through a review of available records and an interview with the patient.

Past Medical History: IBS, endorses a lot of health issues since she was a child

Chief Complaint: Anxiety

History of Present Illness:

Patient believes she is a result of incest. Patient endorses a lot of mental health issues, wants to know what is going on and get help.

Psych ROS: The patient's presenting complaint has occurred in the context of:

Depression: Patient endorses experiencing daily symptoms of depression over the past 20 years. Such episodes included near daily symptoms of poor sleep habits, irritability, feelings of guilt, low energy, poor concentration, poor appetite, being visibly agitated at times, anhedonia, a depressed mood, and suicidal thoughts.

- Mania: Patient denies having any significant history of mania. The patient denied ever experiencing any regular symptoms of None.

Anxiety: Patient endorses experiencing daily symptoms of anxiety over the past 20 years. Such episodes included near daily symptoms of fatigue, irritability, edginess, muscle tension, difficulty falling asleep each night, attention loss, and panic attacks.

- Panic attacks: Patient endorses experiencing one panic attacks/month over the past several years. Such episodes included near daily symptoms of SOB, hyperventilate, unable to regulate emotions, nausea, dizzy, syncope, seizures.

- Psychosis: Patient endorses experiencing symptoms of psychosis over the past several; such symptoms include hallucinations (shadow people) and paranoid thoughts.

- Obsessions/Compulsions: Patient endorses a several year-long history of intermittent symptoms of intrusive thoughts, fear of germs, constantly checking something.

- Attention deficit/Hyperactivity: Patient endorses a several-long history of intermittent symptoms of BH screening score of 30.

- PTSD: Patient endorses a 20 year-long history of recurrent symptoms of hypervigilance, recurrent nightmares, flashbacks, avoidance of particular places and/or people, and a negative overall worldview.

- Bipolar: Patient endorses times talks more and faster than usual; more active than usual; moods speeded up or irritable; elevated and depressed at the same time; self doubt to overconfidence; tearful and crying and then joking and laughing excessively

- BPD: relationships intense and unstable; emotions change very quickly; unstable image of self; in the past made suicidal gestures; paranoid people are out to harm her; experience episodes of stress that she believes it is not real; engaged in frantic efforts to avoid abandonment; engaged in excessive spending, substance abuse (marijuana from age 15, but stopped now), binge eating.

- Schizophrenia: sometimes sees shadow people (usually when under a lot of stress, or not sleep); sometime struggle to trust that things are real; sometimes thinks others are controlling her thoughts and emotions; often feels she has powers that others can't see or appreciate; sometimes difficult to keep track of thinking; often others say it is difficult to understand; sometimes feels like being track or watched at home

Past Psychiatric History:

Previous diagnoses: GAD, PTSD

Outpatient treatment: Patient denies, Outpatient at CCBH a few months ago

Therapist: Currently seeing Caroline Bishop

Psychiatric Hospitalizations: Patient denies

Medications on intake: Patient denies

Past Medication Trials: Ativan (don't want b/c of highly addictive personality), Buspar 7.5 mg bid, Zoloft (went insane), Xanax (helped but highly addictive so she doesn't take)

Other treatments: Patient denies

Suicide Attempts: Patient denies

Self-harm: Patient denies

Substance Use History:

Detox/Drug Rehab history: Patient denies

Tobacco: Vapes- trying to stop

Alcohol: Patient denies

Caffeine: Patient denies

Cannabis: Stopped, start Delta 8 but stopped

Opiates: Patient denies

Other illicit substances: Patient denies

Withdrawal symptoms: Patient denies

Family History:

Family History

Problem Relation Age of Onset

- Hypertension Father
- Cancer Maternal Grandmother

Mother: Patient unsure

Father: Patient unsure

Siblings: Patient unsure

Extended Family: Patient unsure- Endorses schizophrenia runs on mother's side of family

There are maternal family members with a history of psychiatric diagnoses.

Social History:

Gestation & Birth: Patient endorses mother was a drug addict but she was fine.

Early Development & Milestones: Developmental milestones were acheived on time.

Childhood Health: The patient endorses frequent visits to neuro doctor. Patient endorses collapsed lung as a child

Patient's Upbringing: Born and raised by parents. Patient endorses as a child she was abused; they would give her Benadryl and chocolate milk to molest her.

Current Living Situation: In a extend stay hotel, trying to finalize divorce, wants to go to Texas but father of child doesn't want to go there

Education: High School Diploma

Occupations: Exotic dancer

Military history: Never served in military

Access to Firearms: Patient denies

Legal: The patient has no significant history of legal issues.

Relationships: Endorses a strong support

Children: 2.5 year old son

Sexual History: The patient identifies as heterosexual and is not sexually active.

Birth Control Method: Tubal ligation

Religious Affliation: identifies as spiritual

Trauma: Patient endorses sexual, physical, and emotional trauma. Patient endorses history pertinent for TBI/concussions.

Seizures: When she has panic attacks, other times as well

Sleep:Endorses a few hours a night

Appetite: Up and down

Past Medical History:

Medical History

Past Medical History:

Diagnosis Date

- Chlamydia 2012
- Endometriosis

- Mental disorder

  anxiety, depression
- Trauma 2012

  reports abuse from father in 2012

Surgical History

Past Surgical History:

Procedure Laterality Date

- CESAREAN SECTION
- OTHER SURGICAL HISTORY

  peg tube placement
- PR LIGATE FALLOPIAN TUBE,POSTPARTUM

Allergies: Penicillins; Amoxicillin; Sulfa (sulfonamide antibiotics); Vancomycin analogues; and Latex, natural rubber

Medications:

Current Outpatient Medications:

- busPIRone (BUSPAR) 7.5 MG tablet, Take 1 tablet (7.5 mg) by mouth 2 (two) times a day (Patient not taking: Reported on 7/8/2022), Disp: 60 tablet, Rfl: 5
- fluconazole (DIFLUCAN) 150 MG tablet, Take 1 tablet (150 mg) by mouth once a week (Patient not taking: Reported on 7/8/2022), Disp: 12 tablet, Rfl: 0
- hydrOXYzine (ATARAX) 25 mg tablet, Take 1 tablet (25 mg) by mouth 2 (two) times a day as needed for anxiety, Disp: 60 tablet, Rfl: 1
- lorazepam (ATIVAN) 0.5 mg tablet, Take 1 tablet (0.5 mg) by mouth 2 (two) times a day as needed for anxiety (Patient not taking: No sig reported), Disp: 30 tablet, Rfl: 0
- QUEtiapine (SEROquel) 50 mg tablet, Take 1 tablet (50 mg) by mouth nightly, Disp: 30 tablet, Rfl: 1
- traZODone (DESYREL) 50 mg tablet, Take 1 tablet (50 mg) by mouth at bedtime as needed (insomnia) (Patient not taking: No sig reported), Disp: 30 tablet, Rfl: 5

Review of Systems:

Constitutional: Denies current fever, chills or recent weight loss

HEENT: Denies current vision changes hearing problems, and mouth or throat problems

Cardiovascular: Denies current chest pain or dizziness

Respiratory: Denies current wheezing, difficulty breathing

Neuro: Denies current seizures or stroke

Genintourinary: Denies current dysuria, difficulty voiding

Gastrointestinal: Denies current nausea, vomiting, heartburn

Vital Signs:

Weight:

07/08/22 52.7 kg (116 lb 3.2 oz)

Temperature:

07/08/22 98.2 °F (36.8 °C) (Oral)

BP Readings from Last 3 Encounters:

07/08/22 115/77

Pulse Readings from Last 3 Encounters:

07/08/22 80

Physical Exam:

Patient is well-developed and well-nourished in no acute distress. Patient is not in respiratory distress and there is equal chest expansion bilaterally. Moves all four extremities spontaneously with full range of motion. Grossly normal muscle strength and tone based on observations of spontaneous movements. No tics or tremors evident. No atrophy or abnormal movements. Gait and station observed, which were noted to be appropriate.

Mental status exam:

Appearance: age appropriate and casually dressed

Behavior: normal

Speech: normal pitch and normal volume

Mood: "scattered"

Affect: mood-congruent

Thought Process: logical, coherent, and goal-directed.

Thought Content: Patient endorses no thought disturbances; patient denies any None.

Sensorium: person, place and time. .

Suicidality: patient denies any suicidal thoughts or intent; No specific plan to harm self

Homicidality: Pt denies homicidal ideation, intent or plan

Insight: appropriate

Judgement: appropriate

Impulsivity: appropriate

Memory: recent and remote memory intact

Fund of knowledge: appropriate for level of education

Screenings:

PHQ9 /27

GAD7 Feeling nervous, anxious, or on edge: Nearly every day

Not being able to stop or control worrying: Nearly every day

Worrying too much about different things: Nearly every day

Trouble relaxing: Nearly every day

Being so restless that it's hard to sit still: Nearly every day

Becoming easily annoyed or irritable: Nearly every day

Feeling afraid as if something awful might : Nearly every day

GAD-7 Total Score: 21

If you checked off any problems, how difficult have these problems made it for you to do your work, take care of things at home, or get along with other people?: Extremely difficult

Labs:

CBC:

Lab Results

Component	Value	Date
WBC	21.0 (H)	10/24/2019
HGB	8.0 (L)	10/24/2019
HCT	25.0 (L)	10/24/2019
MCV	92.9	10/24/2019
PLT	231	10/24/2019

Chem 7:

Lab Results

Component	Value	Date
NA	140	01/03/2022
K	4.0	01/03/2022
CL	106	01/03/2022
CO2	26	01/03/2022
CREATININE	1.04	01/03/2022
BUN	10	01/03/2022

LFTs:

Lab Results

Component	Value	Date
BILITOT	0.4	01/03/2022
ALBUMIN	4.0	01/03/2022
AST	27	01/03/2022
ALT	32	01/03/2022
PROT	7.1	01/03/2022

HA1C: No results found for: HGBA1C

Lipids: No results found for: CHOL, HDL, LDLCALC, TRIG

Vitamin B12:

Lab Results

Component	Value	Date
VITAMINB12	347	03/29/2019

Folate:

Lab Results

Component	Value	Date
FOLATE	8.0	03/29/2019

Thyroid function studies:

Lab Results

Component	Value	Date
TSH	1.299	01/03/2022

RPR: No results found for: RPR

Prescription Drug Levels No results found for: LITHIUM

No results found for: VALPROIC

No results found for: CBMZ

EtOH: No results found for: ALCOHOL

Urine Tox: No results found for: BARBITURATES, BENZOURQL, CANNABUR, COCAINE, METHSCRNUR, PHENOBARB, UCREAT, PHUR, OPIATES

Suicide Risk Assessment low

Provoking factors

family history of maltreatment, history of mental disorders, particularly clinical depression, feelings of hopelessness.

Protective factors

effective clinical care for mental, physical, and substance abuse disorders, Easy access to a variety of clinical interventions and support for help seeking, family and community support (connectedness), support from ongoing medical and mental healthcare relationships, skills in problem solving, conflict resolution, and non-violent ways to handling disputes, cultural and religious beliefs that discourage suicide and support instincts for self-preservation, engagement in treatment

DIAGNOSIS

		ICD-9-CM	ICD-10-CM	
1.	GAD (generalized anxiety disorder)	300.02	F41.1	hydrOXYzine (ATARAX) 25 mg tablet
2.	Schizoaffective disorder, bipolar type (HCC)	295.70	F25.0	QUEtiapine (SEROquel) 50 mg tablet

PLAN

1. Start Atarax 25 mg bid prn, Seroquel 50 mg (take 1/2-1 tab) q hs
2. Encourage patient to exercise at least 3x/week for 30+ minutes at a time
3. Discussion about sleep hygiene and techniques to improve sleep onset/initation
4. Psychotherapy: Continue with therapy
5. Follow up in 4-6 weeks.

Medications and plan of care have been discussed with client at this appointment, for which they have verbalized understanding.

New medication(s) / current medication(s): continuation, initiation, precautions, and recommendations reviewed today.

Discussed:R/B/SE's

-Patient was educated about treatments including benefits, alternatives, potential medication side effects, and risks of possible lack of treatment. Discussed patients' illness concerns today. We have discussed the benefits and risks of the recommended treatment options and have reviewed therapeutic alternatives, possible outcomes and prognosis. Patient questions were appropriately addressed and answered.

07/08/22