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ELIZABETH JONES, MD
Outpatient Psychiatry

Date of Exam: 9/1/2015
Time of Exam: 7:30:20 AM
Patient Name: Smith, Mia
Patient Number: 1000010660961

CHEMICAL DEPENDENCY ASSESSMENT

Diagnoses: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Alcohol Use Disorder, Moderate, F10.20 (ICD-10) (Active)
Essential (primary) hypertension, I10 (ICD-10) (Active)

Dimension 1: INTOXICATION / WITHDRAWAL RISK RATING: 1, as evidenced by:
Client can tolerate and cope with withdrawal discomfort. The client displays mild to moderate intoxication or signs and symptoms interfering with daily functioning but does not immediately endanger self or others. Client poses minimal risk of severe withdrawal.

Information Re Substance Abuse Received From:
Mrs. Smith

Drug Used:
Mrs. Smith uses the following substance: Alcohol
Tolerance:
*A markedly diminished effect with continued use of the same amount of alcohol.
*Craving, or strong desire or urge to use alcohol.
Impression:
When Mrs. Smith uses substance the quantity used is one bottle of wine per evening.

Pattern of Use: She uses a few times a week.
Mrs. Smith has been using this substance intermittently for years. She last used the substance three days ago.

Withdrawal Symptoms:
Mrs. Smith denies ever experiencing withdrawal symptoms.

Dimension 2: BIOMEDICAL CONDITION/COMPLICATION RISK RATING: 0, as evidenced by:
Client is fully functioning and demonstrates good ability to cope with physical discomfort or there are no current biomedical conditions or complications or symptoms are stable and do not interfere with functioning.

Psychotropic Med History:
Psychotropic medications have never been prescribed for Mrs. Smith.

Dimension 3: MENTAL HEALTH RISK RATING: 0, as evidenced by:
Client has good impulse control and coping skills and presents no risk of harm to self or others. Client functions in all life areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.

Global Assessment of Individual Needs:
Mrs. Smith reports that she has the following:
*Victim of Abuse: Never
*Medical/Detox:
Mrs. Smith denies any serious medical condition or imminent withdrawal symptoms.

Dimension 4: TREATMENT ACCEPTANCE RISK RATING: 1, as evidenced by:
Client is motivated with active reinforcement, to explore treatment and strategies for change, but ambivalent about illness or need for change.

Motivation for Change: Mrs. Smith appears to be well motivated for change.

Addictive Behaviors: Mrs. Smith describes alcohol problems, as are elsewhere described. Mrs. Smith describes a history of an eating disorder.

Dimension 5: RELAPSE POTENTIAL RISK RATING: 1, as evidenced by:
Client recognizes relapse issues and prevention strategies, but displays some vulnerability for further substance use or mental health problems.

Relapse History: Mrs. Smith reports that this evaluation is not relapse related.

Dimension 6: RECOVERY ENVIRONMENT RISK RATING: 3, as evidenced by:
Client is not engaged in structured, meaningful activity, and peers, family, significant other, and living environment are minimally supportive.

HIGHEST RISK RATING:

Dimension 6: RECOVERY ENVIRONMENT RISK RATING: 3, as evidenced by:
Client is not engaged in structured, meaningful activity, and peers, family, significant other, and living environment are minimally supportive.

RECOMMENDATION: Outpatient Treatment.
Condition or behavior requires treatment but condition is stable enough for Outpatient treatment, and there is no apparent danger to self or others.

Elizabeth Jones, LCSW

Electronically Signed
By: Elizabeth Jones, LCSW
On: 9/1/2015 7:31:37 AM

ELIZABETH JONES, MD
Outpatient Psychiatry

Date of Exam: 9/4/2015
Time of Exam: 8:15:20 AM
Patient Name: Smith, Mia
Patient Number: 1000010660961

COMPLETE EVALUATION: OUTPATIENT

History: Mrs. Smith is a married Canadian 38 year old woman. Her chief complaint is, "I worry that I may be drinking too much red wine."

Information Re Substance Abuse Received From:
Mrs. Smith
Mrs. Smith reports that her current relapse is, in part, due to stress.

Drug Used:
Mrs. Smith uses the following substance: Alcohol
The following pattern of use is described:
Tolerance:
*A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.
*Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

Impression:
Mrs. Smith has 2-3 of the above symptoms/behaviors, therefore she is considered to have a Mild Alcohol Use Disorder.
When Mrs. Smith uses substance she uses until she is completely intoxicated.

Pattern of Use: She uses a few times a week. "I need to drink to unwind after a bad day at work."
Mrs. Smith has been using this substance intermittently for years.
Mrs. Smith reports having used this substance last, several days ago. She uses to escape worry.

Problem Pertinent Review of Symptoms/Associated Signs and Symptoms: She describes no depressive symptoms. Symptom reviews of all other systems are negative.

Past Psychiatric History:
Dimension 3: MENTAL HEALTH RISK RATING: 0, as evidenced by:
Client has good impulse control and coping skills and presents no risk of harm to self or others. Client functions in all life areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.

Global Assessment of Individual Needs:
Mrs. Smith reports that she has the following:
*Victim of Abuse: Never
Medical/Detox:
Mrs. Smith denies any serious medical condition or imminent withdrawal symptoms.
Withdrawal Symptoms:
Mrs. Smith denies never experiencing withdrawal symptoms.
Suicidal/Self Injurious:
Mrs. Smith has no history of suicidal or self injurious behavior.
Psychotropic Medication History:
Psychotropic medications have never been prescribed for Mrs. Smith.

Social/Developmental History:
Dimension 4: TREATMENT ACCEPTANCE RISK RATING: 1, as evidenced by:
Client is motivated with active reinforcement, to explore treatment and strategies for change, but ambivalent about illness or need for change.

Motivation for Change: Mrs. Smith appears to be well motivated for change.

Addictive Behaviors: Mrs. Smith describes alcohol problems, as are elsewhere described.

Dimension 5: RELAPSE POTENTIAL RISK RATING: 1, as evidenced by:
Client recognizes relapse issues and prevention strategies, but displays some vulnerability for further substance use or mental health problems.

Relapse History: Mrs. Smith reports that this examination is not relapse related.

Dimension 6: RECOVERY ENVIRONMENT RISK RATING: 3, as evidenced by:
Client is not engaged in structured, meaningful activity, and peers, family, significant other, and living environment are minimally supportive.

Relationship/Marriage:
Times Married, Partnered:
*Married once
The current relationship has lasted:
*More than ten years
The current relationship is described as:
*Tolerable
Children:
Mrs. Smith has no children.
Employment History:
Mrs. Smith is working as a lab technician.
Financial Status:
*Financially comfortable.
Personal Goal(s):
Mrs. Smith's goal(s) are as follows:
"I just want to feel better."

Family History:
Sister hospitalized for alcoholism.
Cousin treated as outpatient for alcoholism. This family member is maternally related.
Mrs. Smith's 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:
Dimension 1: INTOXICATION / WITHDRAWAL RISK RATING: 1, as evidenced by:
Client can tolerate and cope with withdrawal discomfort. The client displays mild to moderate intoxication or signs and symptoms interfering with daily functioning but does not immediately endanger self or others. Client poses minimal risk of severe withdrawal.

Dimension 2: BIOMEDICAL CONDITION/COMPLICATION RISK RATING: 0, as evidenced by:
Client is fully functioning and demonstrates good ability to cope with physical discomfort or there are no current biomedical conditions or complications or symptoms are stable and do not interfere with functioning.

Current Medical Diagnoses:

Cardiovascular:

*Hypertension

Current Medications:

*Lasix and KCL supplement

Reproductive History:

Pregnant:

*Reports that she is not pregnant

Cardiac Disclaimer:

There is no family history of early death due to cardiac arrhythmia or conduction defect or other related cardiac issues.

Medical History is Otherwise Negative:

Mrs. Smith has no other history of serious illness, injury, operation, or hospitalization. She does not have a history of asthma, seizure disorder, head injury, concussion or heart problems. No medications are currently taken.

Mental Status Exam: Mrs. Smith presents as calm, attentive, casually groomed, but looks unhappy. She exhibits speech that is normal in rate, volume, and articulation and is coherent and spontaneous. Language skills are intact. Mood presents as normal with no signs of either depression or mood elevation. Affect is appropriate, full range, and congruent with mood. Associations are intact and logical. There are no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. Associations are intact, thinking is logical, and thought content appears appropriate. Suicidal ideas or intentions are denied. Homicidal ideas or intentions are denied. Cognitive functioning and fund of knowledge are intact and age appropriate. Short and long term memory are intact, as is ability to abstract and do arithmetic calculations. This patient is fully oriented. Vocabulary and fund of knowledge indicate cognitive functioning in the normal range. Insight into problems appears fair. Judgment appears to be poor. There are no signs of anxiety. There are no signs of hyperactive or attentional difficulties. Mrs. Smith made poor eye contact during the examination. No signs of withdrawal or intoxication are in evidence.

Vital Signs:

Sitting blood pressure is 125 / 60. Sitting pulse rate is 78. Pulse is regular. Respiratory rate is 18 per minute. Temperature is 98.4 degrees F.

Diagnoses: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Alcohol Use Disorder, Moderate, F10.20 (ICD-10) (Active)
Essential (primary) hypertension, I10 (ICD-10) (Active)

Clinical Summary:

RISK ASSESSMENT: SUICIDE

History of Risk Factors:

Mrs. Smith has a history of alcohol or substance abuse.

A family member has a history of suicidal behavior. A family member has committed suicide.

Current Risk Factors:

Severe Insomnia is present.

Current alcohol abuse is present.

Protective Factors:

Religious beliefs

Suicide Risk:

Based on the absence of risk factors, Mrs. Smith's current risk of suicide is considered VERY LOW or absent. There are no suicidal ideation or self destructive or aggressive thoughts or actions.

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.

Substance Abuse Counseling
Psychopharmacology

Start Ambien CR 6.25 mg PO QHS PRN x30days # 30 (thirty) None refills (Insomnia)
Start Lasix 20 mg. PO BID (Ordered by PCP)
Start K-Lor 40 meq PO QAM (Ordered by PCP)

NOTES AND RISK FACTORS

History of Subst. Abuse

99202AI (Office / Outpt, New)

Elizabeth Jones, MD

Electronically Signed
By: Elizabeth Jones, MD
On: 9/14/2015 8:15:41 AM

ELIZABETH JONES, MD
Outpatient Psychiatry

Date of Exam: 9/5/2015
Patient Name: Smith, Mia
Patient Number: 1000010660961

PROGRESS NOTE: OUTPATIENT

Interval History: Mrs. Smith seems to have had an inadequate response to treatment as yet.

Problem Pertinent ROS: She has been experiencing dysphoric moods. An appetite or weight change has not occurred. Periods of fatigue are denied. She reports no sleep difficulty. "Ambien is helping me sleep well."

Mrs. Smith acknowledges that she was tempted to use. Mrs. Smith acknowledges that she has used since her last appointment. She reports it was last used days ago. She admits drinking wine.

She reports increased alcohol cravings. She reports difficulty concentrating. She complains of irritability.
"I am having using dreams."

Behavior:
Medication has been taken regularly. She is paying less attention to self care. She reports the feeling of having to force self to function at work. There are early signs of substance abuse problems as current use has increased to an amount greater than advised. Impulsive behaviors continue to be displayed.

She describes no side effects and none are in evidence.

Mental Status Exam: Mrs. Smith appears glum, attentive, casually groomed, and looks unhappy. She exhibits speech that is normal in rate, volume, and articulation and is coherent and spontaneous. Language skills are intact. Signs of mild depression are present. Demeanor is sad. She appears to be near tears. Slowness of physical movement helps reveal depressed mood. She denies having suicidal ideas. Her affect is congruent with mood. Associations are intact and logical. There are no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. Associations are intact, thinking is logical, and thought content appears appropriate. Homicidal ideas or intentions are denied. Cognitive functioning and fund of knowledge are intact and age appropriate. Short and long term memory are intact, as is ability to abstract and do arithmetic calculations. This patient is fully oriented. Vocabulary and fund of knowledge indicate cognitive functioning in the normal range. Insight into problems appears fair. Judgment appears to be poor. There are signs of anxiety. She is easily distracted. Mrs. Smith's behavior in the session was cooperative and attentive with no gross behavioral abnormalities. Mrs. Smith exhibits signs of withdrawal from a chemical. Signs of anxiety which appear to be secondary to withdrawal are present. She is diaphoretic.

Diagnoses: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Alcohol Use Disorder, Moderate, F10.20 (ICD-10) (Active)
Essential (primary) hypertension, I10 (ICD-10) (Active)
Major Depressive Disorder, Single Episode, Moderate, F32.1 (ICD-10) (Active)

Therapy Content:
The patient today spoke mainly about issues involving coping with interpersonal problems. Feelings of low self esteem were also discussed in today's session. Substance abuse problems were also discussed in session today. Guilty feelings were also expressed. “I know drinking has taken time away from my family.”

The focus of today's session was on assessing the type and severity of the problem. This session the therapeutic focus was on educating the patient about symptoms. The patient was today encouraged to ventilate. Help in exploring the patterns of certain behaviors was also given to the patient today. Mrs. Smith was given medication instructions and education. Attendance at AA meetings were encouraged.

Instructions / Recommendations / Plan:
Mrs. Smith will stop associating with peers who are not sober.
Mrs. Smith will begin to implement a sobriety plan.
Couples Therapy
AA

9/2/2015 Started Ambien CR 6.25 mg PO QHS PRN x30 days # 30 (thirty) None refills (Insomnia)
9/2/2015 Started Lasix 20 mg. PO BID (Ordered by PCP)
9/2/2015 Started K-Lor 40 meq PO QAM (Ordered by PCP)
Start Prozac 20 mg PO QAM x30 days # 30 (thirty) None refills (Depression)

NOTES AND RISK FACTORS
History of Subst. Abuse

99214 (Office Pt, Established)
90833 Psychotherapy 30 min. with EM services

Time spent face to face with patient and/or family and coordination of care: 16 to 37 minutes

Elizabeth Jones, MD

Electronically Signed
By: Elizabeth Jones, MD
On: 9/5/2015 8:24:33 AM

ELIZABETH JONES, MD
Outpatient Psychiatry

Date of Exam: 9/6/2015
Patient Name: Smith, Mia
Patient Number: 1000010660961

COUPLES THERAPY: OUTPATIENT

Marital Therapy Note

Marital / Couple: A failure or lack of emotional support is part of the focus of therapy for this couple. Different sexual expectations and needs are a source of this couple's problems and a focus of treatment. Excessive dependency on parents is a problem issue in this couple's relationship and a focus of treatment. No communication or poor communication is a problem for this couple and a focus of their therapy.
Present at today's session were the following:
The Couple: Mia and Stephen Smith

Group Leader Interventions: A focus of treatment today was in assisting the couple to express their needs in a positive and trusting way, instead of criticizing the partner. In therapy today the couple was encouraged to explore what they see in each other that is good and what had initially drawn them to each other. Therapeutic efforts were directed toward reducing reactivity between this couple. Therapeutic work centered around techniques to reduce blame and to teach ownership of one's own vulnerability. Helping this couple accept or "own" their vulnerability instead of blaming the other was the focus of therapy today. Another focus was teaching the couple to listen to each other without judgment or rebuttal.

Mrs. Smith today spoke of self defeating behavior. In addition, she spoke of issues associated with substance abuse. Mrs. Smith describes substance cravings. She admits she was tempted to use. Mrs. Smith denies use. Mrs. Smith reports that she has been regularly attending AA meetings.

Mr. Smith stated, "I am so proud of my wife stepping up and handling this important issue. It gives me hope for the future."

Diagnoses: The following Diagnoses are based on currently available information and may change as additional information becomes available.
Alcohol Use Disorder, Moderate, F10.20 (ICD-10) (Active)
Essential (primary) hypertension, I10 (ICD-10) (Active)

Instructions/Recommendations/Plans
Increase participation for both parties during the couples therapy session.
Attend couples therapy three evenings a week.

NOTES AND RISK FACTORS
History of Subst. Abuse
Marital Discord

90837 Psychotherapy 60 min.

Time spent face to face with patient and/or family and coordination of care: 60 min
Session start: 2:00 PM
Session end: 3:00 PM

Elizabeth Lobao (MD)
Electronically Signed
By: Elizabeth Jones, MD
On: 9/13/2015 7:08:46 AM

ELIZABETH JONES, MD
Outpatient Psychiatry

Date of Exam: 9/9/2015
Patient Name: Smith, Mia
Patient Number: 1000010660961

NURSING PROGRESS NOTE: OUTPATIENT

Symptoms of depression continue to be described by the patient. Mrs. Smith's depressive moods are episodically present. Mrs. Smith depressive moods typically occur a few times a week. Excessive worrying is described. Mrs. Smith describes feeling sad. Mrs. Smith denies suicidal ideas or intentions.

Problem Pertinent ROS: Mrs. Smith describes cravings to use. Mrs. Smith acknowledges that she was tempted to use. Mrs. Smith acknowledges that she has used since her last appointment.

She denies all current symptoms of drug withdrawal.

Behavior:
Medication has been taken regularly. She is having to force self to function fully at work. There are no early signs of substance abuse relapse and sobriety has been maintained. Impulsive behaviors are not reported.

Mental Status Exam: Mrs. Smith presents as calm, downcast, communicative, but slow to respond. Signs of mild depression are present. She is tearful. Slowness of physical movement helps reveal depressed mood. Suicidal ideas are denied. Insight into problems appears fair. Judgment appears fair.No signs of withdrawal or intoxication are in evidence.

Vital Signs:
Sitting blood pressure is 115 / 60. Sitting pulse rate is 80. Respiratory rate is 19 per minute. Temperature is 98.5 degrees F.

Diagnoses: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Alcohol Use Disorder, Moderate, F10.20 (ICD-10) (Active)
Essential (primary) hypertension, I10 (ICD-10) (Active)
Major Depressive Disorder, Single Episode, Moderate, F32.1 (ICD-10) (Active)

NOTES AND RISK FACTORS
History of Subst. Abuse
Active in Couples Therapy

Linda Hamilton, RN

Electronically Signed
By: Linda Hamilton, RN
On: 9/9/2015 9:35:46 AM

ELIZABETH JONES, MD
Outpatient Psychiatry

Date of Exam: 9/12/2015
Patient Name: Smith, Mia
Patient Number: 1000010660961

Interval History: Improvement is noted.

Problem Pertinent Review of Symptoms/Associated Signs and Symptoms: Symptoms of depression are convincingly denied. "Prozac seems to be working perfectly for me after two months. However, I worry that I will be tempted to drink in certain social situations."

Symptoms, as noted, have improved as they are less frequent or less intense. Anergia has lessened. Less anhedonia is reported. Symptoms of sadness have decreased. Mrs. Smith denies suicidal ideas or intentions. Denial is convincing.

Substance use is denied.
She denies all current symptoms of drug withdrawal.

Beck Depression Inventory:
The BDI s a multiple choice self report monitoring test that measures the severity of depression in adolescents and adults. The results and score of Mrs. Smith's test are as follows:
*Mild Depression: (Scored between 10-16) **Exact score is 15.**

Behavior:
Behavior has been stable and uneventful and medication compliance is good.
Sobriety is being maintained with difficulty.
Couples therapy sessions are attended by Mr. and Mrs. Smith three time a week.

She describes no side effects and none are in evidence.

Mental Status Exam: Examination of Mrs. Smith reveals her to have no apparent serious mental status abnormalities. She is normal in appearance with age appropriate dress and grooming and she appears to be her stated age. Neither depression nor mood elevation is evident. Her speech is normal in rate volume and articulation and her language skills are intact. She convincingly denies suicidal and self injurious ideas or intentions. Homicidal or assaultive ideas or intentions are also denied. Hallucinations and delusions are denied and her behavior is generally appropriate. Associations are intact, thinking is basically logical and thought content is appropriate. There are no signs of cognitive difficulty, based on vocabulary and fund of knowledge. Memory is intact for recent and remote events and the patient is oriented to time, place, and person. There are no apparent signs of anxiety. A normal attention span is in evidence and she exhibits no signs of hyperactivity. Insight and judgment appear intact. **No signs of withdrawal or intoxication are in evidence.**

Diagnoses: The following Diagnoses are based on currently available information and may change as additional information becomes available.

Alcohol Use Disorder, Moderate, F10.20 (ICD-10) (Active)
Essential (primary) hypertension, I10 (ICD-10) (Active)
Major Depressive Disorder, Single Episode, Moderate, F32.1 (ICD-10) (Active)

Instructions / Recommendations / Plan:

Antabuse Teaching:
The effective use of Antabuse as a deterrent to impulsive drinking was explained in detail today. Mrs. Smith is told this agent is safe to use with after-shaves, lotions, soaps and mouthwash (unless ingested). It is reinforced that Antabuse is an excellent deterrent against impulsive intake of alcohol. It is also explained that Antabuse can be especially effective if the patient has a history of using ETOH as a "portal of entry" for other substances but would not otherwise abuse other substances if not primed with alcohol.

9/12/2015 Started Ambien CR 6.25 mg PO QHS PRN x30days # 30 (thirty) None refills (Insomnia)
9/12/2015 Started Lasix 20 mg. PO BID (Ordered by PCP)
9/12/2015 Started K-Lor 40 meq PO QAM (Ordered by PCP)
9/12/2015 Started Prozac 20 mg PO QAM x30days # 30 (thirty) None refills (Depression)
Start Antabuse 250 mg. PO BID (ETOH)

NOTES AND RISK FACTORS
History of Subst. Abuse
Attending Couples Therapy
Fear of Relapse: Antabuse started 9/12/15

99214 (Office Pt, Established)

Elizabeth Jones, MD

Electronically Signed
By: Elizabeth Jones, MD
On: 9/12/2015 7:57:25 PM

ARNOLD WALKER, LCSW
Outpatient Psychiatry

Date of Exam: 9/7/2015
Time of Exam: 9:50:45 AM
Patient Name: Smith, Mia
Patient Number: 1000010660961

INDIVIDUAL PSYCHOTHERAPY NOTE

Mrs. Smith shows a partial treatment response. Continued depressive symptoms are reported by Mrs. Smith. Her depressive moods are present episodically. Symptoms occur daily. Symptoms, as noted, have improved as they are less frequent or less intense. She has less anhedonia. There is less irritability reported. She denies suicidal ideas or intentions. Continuing anxiety symptoms have been observed. Mrs. Smith reports improvement as symptoms have lessened in frequency or intensity. There is no change in the frequency of irritability episodes. Startle response is less frequently present. She denies recent substance use. "It has been almost a week since I had a drink."

Problem Pertinent ROS: She describes an improved appetite. Anxiety, which she associates with withdrawal, is described as lessened. She reports continued drug cravings. She complains of fewer headaches. She reports worsening nightmares. "I am still having using dreams."

BEHAVIOR:
Her self care is reduced and less attention is being paid to these tasks. Her relationships with family and friends are reduced. She has maintained sobriety. There have been no reported instances of impulsive behaviors.

CONTENT OF THERAPY:
The patient today spoke mainly about issues involving coping with dependency. Substance abuse problems were also discussed by the patient. Self defeating problems were also discussed. Feelings of shame were also expressed.

THERAPEUTIC INTERVENTION:
The therapeutic focus of today's session was on assessing the type and severity of the problem, helping increase insight and understanding, and education about symptoms. Today's session also focused on issues involving substance abuse and the importance of abstinence. Mrs. Smith was counseled regarding the need for compliance with all medical instructions, particularly having to do with medication.

Diagnoses:
Alcohol Use Disorder, Moderate, F10.20 (ICD-10) (Active)
Essential (primary) hypertension, I10 (ICD-10) (Active)
Major Depressive Disorder, Single Episode, Moderate, F32.1 (ICD-10) (Active)

Instructions / Recommendations / Plan:

Antabuse Teaching:
The effective use of Antabuse as a deterrent to impulsive drinking was explained in detail today. Patient is told this agent is safe to use with after-shaves, lotions, soaps and mouthwash (unless ingested). It is reinforced that Antabuse is an excellent deterrent against impulsive intake of alcohol. It is also explained that Antabuse can be especially effective if the patient has a history of using ETOH as a "portal of entry" for other substances but would not otherwise abuse other substances if not primed with alcohol.

NOTES AND RISK FACTORS
History of Subst. Abuse
Attending Couples Therapy

Time spent face to face with patient and/or family and coordination of care: 30 min
Session start: 11:00 AM
Session end: 11:30 AM

Arnold Walker, LCSW

Electronically Signed
By: Arnold Walker, LCSW
On: 9/7/2015 9:50:51 AM

Thomas Jones, Clinical Psychologist
Outpatient Psychiatry

Date of Exam: 9/5/2015
Time of Exam: 9:01:31 AM
Patient Name: Smith, Mia
Patient Number: 1000010660961

BIO-PSYCHOSOCIAL ASSESSMENT

History: Mrs. Smith is a married Canadian 38-year-old woman. Her chief complaint is, "I don't know when I crossed the line and began drinking this heavily."

Information Re Substance Abuse Received From:

Mrs. Smith: Mrs. Smith reports that her current relapse is, in part, due to stress. Details are as follows:

Drug Used:

Mrs. Smith uses the following substance:

Alcohol: The following pattern of use is described:

*There is a persistent desire or unsuccessful efforts to cut down or control alcohol use.

*Important social, occupational, or recreational activities are given up or reduced because of alcohol use.

Tolerance:

*A need for markedly increased amounts of alcohol to achieve intoxication or desired effect.

Impression:

Mrs. Smith has 4-5 of the above symptoms/behaviors, therefore she is considered to have a Moderate Alcohol Use Disorder.

When Mrs. Smith uses substance the quantity used is an amount that she can not identify.

Pattern of Use:

Mrs. Smith's substance use is continuous. She uses daily.

Mrs. Smith has been using this substance for years.

Mrs. Smith reports having used this substance last, days ago. She uses to escape worry.

Anxiety Symptoms:

Mrs. Smith exhibits symptoms of anxiety.

Mrs. Smith describes the following anxiety symptoms:

*Avoidance

*Difficulty concentrating occurs.

Mrs. Smith's symptoms are occurring multiple times a day. She reports previous episodes of anxiety symptoms. Mrs. Smith's first episode of anxiety occurred at age 17. The length of her first episode of anxiety symptoms was approximately three months. Mrs. Smith has never been treated for anxiety symptoms. "I drink heavily when I am anxious after work."

Past Psychiatric History:

Dimension 3: MENTAL HEALTH RISK RATING: 0, as evidenced by:

Client has good impulse control and coping skills and presents no risk of harm to self or others. Client functions in all life areas and displays no emotional, behavioral, or cognitive problems or the problems are stable.

Global Assessment of Individual Needs:

Mrs. Smith reports that she has the following:

*Victim of Abuse: Never

Medical/Detox:

Mrs. Smith denies any serious medical condition or imminent withdrawal symptoms.

Withdrawal Symptoms:

Mrs. Smith denies ever experiencing withdrawal symptoms.

Suicidal/Self Injurious:
Mrs. Smith has no history of suicidal or self injurious behavior.
Psychotropic Medication History:
Psychotropic medications have never been prescribed for Mrs. Smith.

Social/Developmental History:

Dimension 4: TREATMENT ACCEPTANCE RISK RATING: 1, as evidenced by:
Client is motivated with active reinforcement, to explore treatment and strategies for change, but ambivalent about illness or need for change.

Motivation for Change: Mrs. Smith appears to be well motivated for change.

Addictive Behaviors: Mrs. Smith describes alcohol problems, as are elsewhere described. Mrs. Smith describes a history of an eating disorder.

Dimension 5: RELAPSE POTENTIAL RISK RATING: 1, as evidenced by:
Client recognizes relapse issues and prevention strategies, but displays some vulnerability for further substance use or mental health problems.

Relapse History: Mrs. Smith reports that this admission is not relapse related.

Dimension 6: RECOVERY ENVIRONMENT RISK RATING: 3, as evidenced by:
Client is not engaged in structured, meaningful activity, and peers, family, significant other, and living environment are minimally supportive.

Relationship/Marriage:
Times Married, Partnered:
*Married once
The current relationship has lasted:
*More than ten years
The current relationship is described as:
*Tolerable
Children:
Mrs. Smith has no children.
Employment History:
Mrs. Smith is working as a lab technician.
Financial Status:
*Financially comfortable.
Personal Goal(s):
Mrs. Smith's goal(s) are as follows:
"I just want to feel better."

Family History:
Sister hospitalized for alcoholism. "She drinks less than I do!"
Cousin treated as outpatient for alcoholism. This family member is maternally related.
Mrs. Smith's 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:
Dimension 1: INTOXICATION / WITHDRAWAL RISK RATING: 1, as evidenced by:
Client can tolerate and cope with withdrawal discomfort. The client displays mild to moderate intoxication or signs and symptoms interfering with daily functioning but does not immediately endanger self or others. Client poses minimal risk of severe withdrawal.

Dimension 2: BIOMEDICAL CONDITION/COMPLICATION RISK RATING: 0, as evidenced by:
Client is fully functioning and demonstrates good ability to cope with physical discomfort or there are no current biomedical conditions or complications or symptoms are stable and do not interfere with functioning.

Current Medical Diagnoses:
Cardiovascular:
*Hypertension
Current Medications:
*Lasix and KCL supplement.
Reproductive History:
Pregnant:
*Reports that she is not pregnant
Pain:
Mrs. Smith denies current pain.
Cardiac Disclaimer:
There is no family history of early death due to cardiac arrhythmia or conduction defect or other related cardiac issues.
Medical History is Otherwise Negative:
Mrs. Smith has no other history of serious illness, injury, operation, or hospitalization. She does not have a history of asthma, seizure disorder, head injury, concussion or heart problems. No medications are currently taken.

Mental Status Exam: Mrs. Smith presents as calm, distracted, casually groomed, and unhappy. She exhibits speech that is normal in rate, volume, and articulation and is coherent and spontaneous. Language skills are intact. Demeanor is glum. She appears downcast. Slowness of physical movement helps reveal depressed mood. Suicidal ideas have been occurring but no suicidal intentions are present. Affect is appropriate, full range, and congruent with mood. Associations are intact and logical. There are no apparent signs of hallucinations, delusions, bizarre behaviors, or other indicators of psychotic process. Associations are intact, thinking is logical, and thought content appears appropriate. Vocabulary and fund of knowledge indicate cognitive functioning in the normal range. Insight into problems appears fair. Judgment appears to be poor. There are signs of anxiety. She is easily distracted. Mrs. Smith is fidgety. Mrs. Smith made poor eye contact during the examination. Mrs. Smith exhibits signs of withdrawal from a chemical. Signs of anxiety which appear to be secondary to withdrawal are present. She is diaphoretic. She is tremulous.

Diagnoses:
Alcohol Use Disorder, Moderate, F10.20 (ICD-10) (Active)
Essential (primary) hypertension, I10 (ICD-10) (Active)
Major Depressive Disorder, Single Episode, Moderate, F32.1 (ICD-10) (Active)

Inventory:
The **Beck Anxiety Inventory**: (A multiple choice self report monitoring test that measures the severity of anxiety in adolescents and adults.)
Mrs. Smith scored between 19-29, indicating moderate to severe anxiety. Her exact score on the BAI is 27.

SNAP: The patient has identified the following strengths, needs, abilities and preferences as well as goals and desired accomplishments. This information will be used in the development of the patient's personal achievement agenda.

STRENGTHS:
*Support from my family (parents, children, other)
NEEDS:
An explanation of my diagnoses.
Education on improving my health.
ABILITIES:
I can fulfill program obligations.
I can be honest in group discussions.

PREFERENCES:
*Individual Therapy
*Education Classes
SPECIFIC ISSUES:
*Alcoholism
*Anxiety
GOALS: "Moving forward, I am committed to maintaining my sobriety."
DESIRED OUTCOME:
*My health will improve.

NOTES AND RISK FACTORS
History of Subst. Abuse
Self medicates for chronic anxiety.

90791 Bio-Psychosocial Initial Assessment

Thomas Jones, Clinical Psychologist

Electronically Signed
By: Thomas Jones, Clinical Psychologist
On: 9/26/2015 9:05:29 PM

KAREN JOHNSON, LCSW
Outpatient Psychiatry

Date of Exam: 9/4/2015
Time of Exam: 9:35:55 AM
Patient Name: Smith, Mia
Patient Number: 1000010660961

Progress Note by ASAM Dimension

Dimension 1: Intoxication/Withdrawal:
*Last Week Rating: 2: (Moderate risk of severe withdrawal.)
*This Week Rating: 1: (Minimal risk of severe withdrawal.)
*Comment: Minimal withdrawal symptoms.

Dimension 2: Medical Problems/Complications:
*Last Week Rating: 2: (Can tolerate and cope with medical problem(s) with difficulty.)
*This Week Rating: 2: (Can tolerate and cope with medical problem(s) with difficulty.)
*Comment: "If I stop drinking completely, how will I cope with my anxiety?

Dimension 3: Behavioral or Mental Health Problem:
*Last Week Rating: 3: (Can poorly tolerate and cope with behavioral or emotional problems.)
*This Week Rating: 2: (Can tolerate and cope with behavioral or emotional problems. with difficulty.)
*Comment: Attending and participating in sobriety group session daily for past week.

Dimension 4: Treatment Acceptance:
*Last Week Rating: 2: (Low motivation for change or treatment.)
*This Week Rating: 1: (Ambivalent about need for change or treatment.)
*Comment: Interested in finding a sponsor.

Dimension 5: Relapse Potential:
*Last Week Rating: 2: (Minimal understanding of relapse risks.)
*This Week Rating: 1: (Some vulnerability to relapse.)
*Comment: Making good progress meeting relapse treatment plan short term goals

Dimension 6: Recovery Environment:
*Last Week Rating: 1: (Client's recovery environment is passive or not interested.)
*This Week Rating: 1: (Client's recovery environment is passive or not interested.)
*Comment: Will return to family home.

SYMPTOMS:
She denies recent substance use.
She denies all current symptoms of drug withdrawal. "When I am in groups, I feel great."

BEHAVIOR:
There are no early signs of substance abuse relapse and sobriety has been maintained. Impulsive behaviors are not reported. "I don't know if I can stay sober for the long haul."

Diagnoses:
Alcohol Use Disorder, Moderate, F10.20 (ICD-10) (Active)
Essential (primary) hypertension, I10 (ICD-10) (Active)
Major Depressive Disorder, Single Episode, Moderate, F32.1 (ICD-10) (Active)

Instructions / Recommendations / Plan:
Mrs. Smith will actively seek an experienced AA sponsor.
Mrs. Smith will stop associating with peers who are not sober.

NOTES AND RISK FACTORS
History of Subst. Abuse
Attending Couples Therapy

90832 Psychotherapy 30 min.

Time spent face to face with patient and/or family and coordination of care: 30 min
Session start: 8:00 AM
Session end: 8:30 AM

Karen Johnson, LCSW

Electronically Signed
By: Karen Johnson, LCSW
On: 9/4/2015 9:35:59 AM