Headway

Intake Template

Provider Name: **Susan Practitioner, LCSW**
Provider NPI: **12345678**

Client Full Name: **Katie Client**
Client Date of Birth: **9/9/1999**

Date of Service: **3/08/2023**

Exact start time and end time: **10:23am-11:20am: 57 mins**

Session Location: **Telehealth, patient provided consent to telehealth, service performed on HIPAA compliant software**

Diagnoses (in words):

Major Depressive Disorder, Moderate, Single episode Chief Complaint: Katie presents to initial session with report of worsening depression over the last month. Informs therapist she was previously diagnosed in 2019, has been to therapy in the past and finds it helpful. Says she was doing well until she lost her job 3 months ago. Once she found a new job her boyfriend ended their relationship

Psych review of Symptoms:

Patient reports difficulty falling asleep, difficulty staying asleep, depressed mood 5/7 days, denies impulsivity denies eating concerns/issues, denies avh, endorses somatic symptoms of headaches, reports "some" childhood trauma

Medical Review of Symptoms:

Patient denies any active medical conditions

History:

Current medication: denies
Developmental: normal per patient knowledge
Family psychiatric: mother-depression, father-alcoholism, brother-"only normal one"
Psychiatric: hx of major depression first diagnosed in 2019
Medical: none
Medication trials: none
Social: "normal" social support, has good relationship with father, mom passed in 2018, 3-4 good friends "plenty" associates and co-workers
Substance use: occasional/social use feels that she is in control of substance use

Mental Status Exam:

Fictitious case

Appearance: well groomed
Attention: good
Behavior: normal
Memory: intact
Mood: sad
Affect: flat
Judgment: fair
Speech: normal
Thought content: no SI/HI/AVH, no paranoia, no delusions
Thought process: linear/logical
Orientation: x4

Risk Assessment

Suicidal ideation: denies, no prior attempts, no prior gestures, +passive SI 1+yr ago
Homicidal ideation: denies, no history
Violent/destructive behaviors: denies, no hx
Current Overall Risk: low risk
Protective Factors: future oriented, help seeking, good social supports
Static risk factors: hx passive SI, family hx of MH, childhood trauma
Modifiable risk factors: current low mood, lack of coping skills

Assessment:

Katie presents with symptoms consistent with mood disorder, she describes her overall mood as "i have nothing to look forward to," "i feel bad for existing," and "i randomly feel like i have a lump in my throat." Described mood consistent with DSM-5 criteria for Major depressive disorder of worthlessness, feelings of guilt, she endorses sleep disturbance of difficulty falling asleep, low energy/fatigue and difficulty concentrating. Therapist helped Katie process her feelings, provided in depth psychoeducation on depression overall, and relevant symptoms that she is experiencing such as guilt and low energy.

Plan:

Therapist will utilize both motivational interviewing and CBT-Depression to help Katie learn coping skills to manage depression symptoms specifically feelings of guilt. Therapist recommends weekly sessions, Katie is in agreement with this. Next session, therapist and Katie will complete the treatment plan.

Electronically signed by: **Susan Practitioner, LCSW**
Note signed date: **3/08/2023**

Fictitious case