Psychotherapy Intake Note

Overcomers Counseling
Clinician: Jennifer Luttman, LPC, ACS
Patient: Example Example, DOB 1/1/1982

Date and Time: February 2, 2023 9:00AM - 10:00AM
Duration: 60 minutes
Service Code: 90791
Location: Erindale Dr (in office)
Participants: Client only

Presenting Problem

The client expressed seeking out therapy to address concerns regarding “I just really wanna work through all this and get myself back on track” regarding her recent significant life changes including "moving, divorce, and separation from my kid." The client reported symptoms of major depressive disorder and generalized anxiety disorder such as fatigue, difficulty concentrating, anxious and catastrophic thinking, worry, suicidal ideation, and difficulty sleeping. The client reports these symptoms began in 2021 and have been progressively getting worse each year with the symptoms becoming "unbearable" in the past three months. The client reports these symptoms are present in her home life, and at work, and affect all of her personal relationships with a "pretty severe" impact happening in each area of her life. The client denied previous efforts at self-help and states that she currently does not have any tools to use that make her symptoms better.

Current Mental Status

Orientation:	X3: Oriented to Person, Place, and Time	Insight:	Poor
General Appearance:	Appropriate	Judgment/Impulse Control:	Poor
Dress:	Appropriate	Memory:	Intact
Motor Activity:	Tense	Attention/Concentration:	Good
Interview Behavior:	Appropriate	Thought Process:	Unremarkable
Speech:	Verbose, Soft	Thought Content:	Appropriate
Mood:	Depressed, Anxious	Perception:	Unremarkable
Affect:	Flat, Tearful	Functional Status:	Severely Impaired

Risk Assessment

Area of Risk:	Suicidal ideation
Level of Risk:	High
Intent to Act:	No
Plan to Act:	Yes
Means to Act:	Yes
Risk Factors:	Current ideation (every other day per her report), Access to means, History of attempts/behaviors, Hopelessness
Protective Factors:	Children in her life, Improving therapeutic rapport
Additional Details:	The client reported SI "every other day" related to feelings of hopelessness, uselessness, worthlessness, and "what's the point" and she denied any recent or current HI and AH/VH. A CSSR was completed with the client indicating severe risk. A safety plan was created with the client and has been uploaded to the portal. The clinician also provided the client with emergency/crisis information.

Objective Content

The client presented as actively engaged during her intake session which was held in person at the therapist's office. Topics covered during the intake session included reviewing this clinician's disclosure statement, consent for services, about me, confidentiality,

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mandated reporting, payment policy, HIPAA privacy practices, Medicaid rights and responsibilities, teletherapy informed consent, and no-show/cancellation policy. The clinician asked the client about speaking with either her primary care physician (PCP) or other mental health providers. The client agreed to the clinician coordinating treatment with her prescribing NP, so an ROI was filled out and will be uploaded to the client's file.

Biopsychosocial Assessment

Identification: The client reported she identifies as a 41-year-old (at the time of intake) caucasian, female, in a committed relationship, with no significant religious affiliation, and resides alone in Colorado Springs, CO.

History of Present Problem: The client reported symptoms of major depressive disorder and generalized anxiety disorder both began in roughly January of 2021 due to multiple moves, a divorce from a toxic relationship, and separation from her child. The client reports that she did not experience any symptoms of depression or anxiety prior to January of 2021.

The client's symptoms of major depression include; low mood, anhedonia, sleep/appetite disturbances, fatigue, feeling bad about herself, difficulty concentrating, psychomotor retardation, and SI. The client reported these symptoms have occurred daily for at a minimum of 3 hours each day all the way to all 12 hours of her day. The client reports depending on the day the severity of these symptoms is moderate-severe and they impact her ability to get out of bed, be a good mother, engage in getting a new job, and maintain strong relationships with others.

The client's symptoms of generalized anxiety include; feeling anxious, catastrophic thoughts, increased heart rate, restlessness/muscle tension, avoidant behaviors regarding situations that elicit anxiety, indecisiveness, seeking external reassurance, and inability to manage her anxiety on her own. The client reported these symptoms have "often-always been present every single day for over the past 2 years" throughout the day, at severe severity, and she recognized a significant impairment in daily, occupational, social, relationship, mental, and self-care functioning as evidenced by her report, “I can't sit still, my mind is racing a million miles a minute and I can't make a decision to save my own life.”

Psychiatric History: The client denied engaging in therapy prior to this intake session. She denied previous hospitalizations for mental health concerns but reported a suicide attempt via overdose (I took a handful of Trazodone) in 2021 between Thanksgiving and Christmas "after being by myself for a while" and reported she woke up the next day feeling very groggy.

Trauma History: The client reported she has been mentally and physically abused by her ex ("He mentally beat me down and he has hit me"), which lead to a "tulmulterous divorce." The client also reported being "hit by her father" when she was a child (see family history section).

Family Psychiatric History: The client reported on her intake paperwork her mother and sister have been previously hospitalized for mental health concerns but did not provide additional information.

Medical Conditions & History: The client reported her last attended physical was on 1/9/2023 and reported "Comfort Dental" regarding her dental history. The client denied any current medical conditions and reported that she has no allergies.

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Current Medications:	The client reported she is prescribed Prozac prescribed by PN - Alyssa Smith. The client takes this daily to manage her symptoms of depression and anxiety. The client was unsure what dosage she has been prescribed, but will provide this information at the next session.
Substance Use:	The client denied any significant history of substance use for herself or anyone in her family.
Family History:	The client reported being born and raised in California and reports her childhood was "normal for the most part." The client reported her biological father used to "hit me a lot when I was a kid and would disobey him." The clinician asked if this had been reported at the time to which the client reported no it was not. No report will be made at this time due to her Father being deceased. The client reports that as she got into her teen years her mother and sister both began to deal with their own mental health struggles which caused some strain on the family dynamics. The client described her current relationship with her mother as "close," when her father was alive their relationship was "distant," (he passed 8 years ago), and with her 2 siblings as "one good, one not so good."
Social History:	The client denied any healthy social support in Colorado. She reported her primary social support is one friend from high school who still lives in California.
Spiritual/Cultural Factors:	The client denied any spiritual affiliation and identifies as Caucasian. She denied any concerns her religious or cultural affiliation will have an impact on her treatment.
Developmental History:	The client did not disclose any signficiant developmental history, but states "I think I did everything on time."
Educational/Vocational History:	The client reported she finished high school, but never took any higher level education after that. She reported that she currently works for Instacart.
Legal History:	The client denied any signifcant legal history other than her involvements in the courts for her divorce.
SNAP:	S: The client reported her strengths are that she is "a really good worker and I try to make sure everyone is okay." N: The client reported her needs are to "learn to calm down, and be happy." The clinician identifies her need to improve her assertiveness, healthy boundary-setting, and her interpersonal relationships. A: The client reported her abilities are that she has average intelligence, she is able to read/write, she has computer skills that allow her to access teletherapy sessions, she has transportation so she can attend in-person sessions, and she reports that she has good insight into her need for therapy which will aid her in the therapeutic process. P: The client reported her preferences are to meet in person as often as possible.
Other Important Information:	The client completed DSM-5-TR Self-Rated Level 1 Cross-Cutting Symptom Measure - Adult indicating further assessments related to depression, and anxiety. Severity Measure for Depression - Adult (adapted from the PHQ-9) indicating severe depression (25/27). Severity Measure for GAD - Adult indicating severe anxiety (34/40). All assessments have been uploaded to the client's file and she reported these scores are an accurate reflection of her symptoms. The client also received a psychoeducational worksheet to complete prior to her next session related to therapy goals.

Plan

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During the next session, the clinician will work with the client to complete her initial treatment plan. The client expressed the following goals for treatment: “To not feel so overwhelmed and conquer my depression and anxiety.” See the treatment plan document for the full treatment plan. The client will attend individual outpatient therapy sessions weekly where the clinician will offer communication, coping, grounding, and self-regulation skills and provide support and guidance in processing the client’s distress. No outside referrals are appropriate at this time however if the need arises the clinician will make the appropriate referrals to outside agencies.

Diagnosis

F32.2 Major Depressive Disorder, Single episode, Severe
F41.1 Generalized Anxiety Disorder

Major Depressive Disorder, Single episode, Severe:
The client reported the following symptoms that meet the diagnostic criteria for major depressive disorder: She reported her symptoms of depressed mood most of the day, nearly every day (feelings of hopelessness), anhedonia (poor interest in activities), sleep and appetite disturbances (insomnia and a lack of appetite), fatigue (low energy/motivation), feeling bad about herself (worthlessness/uselessness), difficulty concentrating (on the task at hand), psychomotor retardation (moving slower than usual), and SI (every other day) have been present most days to nearly every day for the past 2 years and represent a change from previous functioning. The episode is not attributable to the physiological effects of a substance, another medical condition, cannot be better explained by any schizophrenia spectrum or psychotic disorder, and she denied ever having a manic or hypomanic episode.

Generalized Anxiety Disorder:
The client reported the following symptoms that meet the diagnostic criteria for a generalized anxiety disorder: She experiences excessive anxiety and worry about her previous and current relationship, her ability to obtain a job, and her future living situation occurring nearly every day for the past two years and finds it difficult to control the worry (ruminative thoughts). She reported her anxiety manifests in the form of feelings of restlessness (difficulty relaxing, increased heart rate), easily fatigued (physically and mentally), difficulty concentrating (indecisiveness due to overthinking), irritability (toward herself and others), muscle tension (per her report), and sleep disturbances (difficulty falling/unsatisfying sleep). Her symptoms are not attributable to the effects of substance use, another medical condition, or another mental disorder.

Jennifer Luttman, LPC, ACS, Therapist, License #LPC.0006503 signed this note and declared this information to be accurate and complete on February 2, 2023 at 2:45PM.