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