PSYCHIATRIC CLINIC, LLC
123 Main Street
Anywhere, US 12345-6789
555-678-9100 (O)
555-678-9111 (F)

7/20/2017

Nesmith, Kelly

ID: 1000010668241 DOB: 4/30/1987

Discharge Summary

DATE ADMITTED: 4/24/2017
DATE DISCHARGED: 7/20/2017

This discharge summary consists of

1. Initial Assessment
2. Course in Treatment
3. Clinician's Narrative
4. Discharge Status and Instructions

---

1. INITIAL ASSESSMENT

4/26/2017 Complete Evaluation / Psychosocial

History: Ms. Nesmith is a divorced Caucasian 29-year-old woman. Her chief complaint is, "I'm depressed."

Information Received From:
Ms. Nesmith
Ms. Nesmith's Family

Depression History:
Ms. Nesmith describes symptoms of a depressive disorder. The apparent precipitant(s) that caused the depressive mood symptoms are as follows:
*Economic Stress
*Divorce, last year.

Speed of Onset and Course:
Ms. Nesmith's depressive symptoms began gradually over a period of months. Depression is described as episodic. Her depressive episodes are occurring daily and they last for hours.

Prior Depressive/Manic Episodes: There have been no prior depressive episodes reported. No prior manic or hypomanic episodes are reported.

Current Symptoms:
Ms. Nesmith's reported depressive symptoms are as follows:

*Appetite has Decreased
*Concentration Difficulties
*Has "Crying Spells"
*Fatigue
*Increased Worrying
*Sadness
*Affecting work punctuality.
*Ms. Nesmith is late to work due to depressive episodes.

Suicidality:

Ms. Nesmith denies suicidal ideas or intentions.

Severity/Complexity:

Ms. Nesmith's severity is estimated to be moderate based on the risk of morbidity without treatment and description of interference with functioning.

Feelings of excessive or unusual anxiety are denied. She specifically denies manic symptoms. She reports no hallucinations, delusions or other symptoms of psychotic process.

Past Psychiatric History:

Information Received From:

*The family

Psychiatric Hospitalization:

Ms. Nesmith has never been psychiatrically hospitalized.

Outpatient Treatment:

Has never received outpatient mental health treatment.

Suicidal/Self Injurious:

Ms. Nesmith has a history of suicidal thoughts but has never made an attempt.

Assault History:

Ms. Nesmith has been assaultive. She has been in fights but has never seriously injured anyone.

Addiction/Use History:

Ms. Nesmith has a history of possible alcohol over use.

Past psychiatric history is otherwise entirely negative.

Nesmith, Kelly

ID: 1000010668241 DOB: 4/30/1987

Discharge Summary

Social/Developmental History:
Ms. Nesmith is a divorced 29 year old woman. She is Caucasian.

Childhood History: She is an only child.
Quality of childhood was:
*Emotionally and economically supportive and maritally intact.

Relationship/Marriage:
Divorce and Separation:
*Marriage ended in Divorce - 2016 due to spouse's infidelity.

Children:
Ms. Nesmith has two children. (from previous marriage)

Educational History:
Ms. Nesmith graduated from college.

Employment History:
Ms. Nesmith is working as an accountant.

Military History:
Ms. Nesmith never served in the military.

Residence Status:
Ms. Nesmith owns a home. It is reportedly in good repair and safe.

Criminal Justice History:
Ms. Nesmith has never been arrested or incarcerated, has no history of violence, and is not currently under any kind of court supervision.

Gestational & Developmental Histories:
Ms. Nesmith’s gestational and developmental histories were normal.

Family History: There is family history of depression in primary and secondary degree relatives.
Ms. Nesmith'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:

Adverse Drug Reactions:
There is no known history of adverse drug reactions.

Nesmith, Kelly

ID: 1000010668241 DOB: 4/30/1987

Discharge Summary

Allergies:

There are no known allergies.

Current Medical Diagnoses:

None

Current Medications:

None

Medical History is Otherwise Negative:

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

Exam: Ms. Nesmith presents as sad looking, guarded, communicative, well groomed, normal weight, and looks unhappy. Her speech is mumbled, slow, slurred, and soft. There is no difficulty naming objects or repeating phrases. Sad demeanor reveals underlying depressed mood. Affect is appropriate, full range, and congruent with mood. 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. Insight into problems appears fair. Judgment appears fair. There are no signs of anxiety. She is easily distracted. Ms. Nesmith made poor eye contact during the examination.

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

Adjustment disorder with depressed mood, F43.21 (ICD-10) (Active)
R/O Major depressive disorder, single episode, moderate, F32.1 (ICD-10) (Active)

Instructions / Recommendations / Plan:
A clinic or outpatient treatment setting is recommended because client is impaired to the degree that there is relatively moderate interference with occupational functioning. Attend one group once per week. Cognitive Behavioral Therapy: 1x week □for 6 months.

Return 1 week, or earlier if needed.

90791 Psych Diagnostic Interview

Nesmith, Kelly

ID: 1000010668241 DOB: 4/30/1987

Discharge Summary

Time spent face to face with patient and/or family and coordination of care: 1 hour

Rae Morris, (LPC)

---

2. COURSE IN TREATMENT

4/27/2017 Treatment Plan

Treatment Plan for Kelly Nesmith
A treatment plan was created or reviewed today, 4/27/2017, for Kelly Nesmith.

This was a Initial Treatment Team Meeting.

Diagnosis:
Adjustment disorder with depressed mood, F43.21 (ICD-10) (Active)
R/O Major depressive disorder, single episode, moderate, F32.1 (ICD-10) (Active)

Current Medications:
No Active Medications

Problem / Needs:
Problem / Need # 1: Substance Abuse/Dependence

Problem / Need: Substance Abuse/Dependence

PROBLEM: **ETOH**
Ms. Nesmith's substance abuse/dependence has been identified as an active problem requiring treatment. It is primarily evidenced by:
Alcohol Abuse/Dependence: Details as follows:
*Possible Dependence to Alcohol

LONG TERM GOAL:
Ms. Nesmith will establish and maintain total abstinence while increasing knowledge of the substance abuse disorder and the process of recovery.

SHORT TERM GOAL(S) & INTERVENTIONS:
Short Term Goal / Objective:
Ms. Nesmith will attend sessions as recommended multiple times a month to overcome emotional problems.

Intervention:
Therapist/ Counselor will provide Ms. Nesmith with sessions to overcome emotional problems. Progress will be monitored and documented.

Barriers

Ms. Nesmith's barriers include:

- Poor insight
- Need for coping skills

Strengths

Ms. Nesmith's strengths include:

- Intellectually bright
- Spouse is currently supportive

---

3. CLINICIAN'S NARRATIVE

Course During Treatment:

Ms. Nesmith has been compliant with treatment and active participation in therapy. Her outlook on life has noticeably moved in a more positive direction and depressed mood and guilty feelings have decreased significantly.

---

4. DISCHARGE STATUS AND INSTRUCTIONS

Final Exam, Interval History

Ms. Nesmith's behavior has been stable and uneventful and she denies any psychiatric problems or symptoms.

Problem Pertinent Review of Symptoms/Associated Signs and Symptoms: Psychotic, depressive, and anxiety symptoms are denied.

THERAPY CONTENT/CLINICAL SUMMARY:

Client described that her guilty feelings have been relived and she has a better understanding on how to cope with her depression as a result.

The patient was today given emotional support. Ms. Nesmith was counseled and educated regarding the prognosis of the diagnosed condition. She expressed understanding and says she is "better aware thanks to the coping skills you taught me."

THERAPY CONTENT/CLINICAL SUMMARY:

Client described that her guilty feelings have been relived and she has a better understanding on how to cope with her depression as a result.

The patient was today given emotional support. Ms. Nesmith was counseled and educated regarding the prognosis of the diagnosed condition. She expressed understanding and says she is "better aware thanks to the coping skills you taught me."

Final Exam, Mental Status Exam

Mood is euthymic with no signs of depression or elevation. Her speech reveals no abnormalities of rate, volume, or articulation and her language skills are intact. She convincingly denies suicidal ideas. There are no signs of psychotic process. Her behavior is basically appropriate and there are no indications that hallucinations or delusions are present.

There are no signs of a thought disorder. Associations are intact, thinking is generally logical, and thought content is

Nesmith, Kelly

ID: 1000010668241 DOB: 4/30/1987

Discharge Summary

appropriate. Cognitive functioning, based on vocabulary and fund of knowledge, is commensurate with her age and abilities. She is oriented to time and place and can remember recent and remote events. Patient is able to think abstractly. No signs of anxiety are present. There are no signs of hyperactive or attentional difficulties. Insight and judgment are generally intact.

Discharge Diagnosis
Adjustment disorder with depressed mood, F43.21 (ICD-10) (Active)
R/O Major depressive disorder, single episode, moderate, F32.1 (ICD-10) (Active)

Type of Discharge: Regular

Condition on Discharge: Greatly improved

Prognosis: Excellent

Disposition: Care of Family

Consent: Patient was advised regarding the risks and benefits of treatment.

Physical Activity: No limitations on physical activity

Emergency Contact:
555-678-9100 (O)
555-678-9111 (F)

Rae Morris, (LMFT)

Electronically Signed
By: Rae Morris, (LMFT)
On: 7/20/2017 10:16:58 AM